pa group℠ | ACCIDENT & HEALTH

MEDICAL CLAIM FORM

POLICYHOLDER INFORMATION

1. Name of Primary Policyholder (Last, First, MI): ______________________________

2. Policy Number: ______________________________

3. Physical Mailing Address: ______________________________

4. Telephone: ______________________________ **5.** Email Address: ______________________________

PATIENT INFORMATION

6. Patient Name (Last, First, MI): ______________________________

7. Date of Birth (MM/DD/YYYY): ______________________________

CLAIM INFORMATION

8. Was this claim pre-certified? ☐ YES ☐ NO

9. Is the claim covered by another insurance? ☐ YES ☐ NO *If Yes, please provide the name of the insurance company:*

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Note: If your claim was submitted to a local insurance provider, you must submit a copy of the Explanation of Benefits (also referred to as finiquito) and medical bill before our company can process the claim.

10. Type of Service:

☐ Routine Wellness ☐ Medical ☐ Maternity ☐ Routine Vision ☐ Accident

☐ Other: ______________________________

11. Length of days: ______________________________ **12.** Date of onset of the illness (MM/DD/YYYY): ______________________________

13. Admitted as: ☐ Inpatient ☐ Outpatient ☐ Emergency **14.** Country of Treatment: ______________________________

15. List of medical services:

Note: Each one of the items listed below is required to have a copy of the corresponding medical invoice in PDF format.

	Date of Service MM/DD/YYYY	Place of Service	Diagnosis and Procedure	Amount & Currency
a.				
b.				
c.				
d.				
			Total:	

PAYMENT INFORMATION FOR REIMBURSEMENT

16. Please provide the following bank details for reimbursement via wire transfer or ACH payment.

a. Account Number: ______________________________

b. Name of the Account Holder: ______________________________

c. Routing Number: ______________________________

d. Name of Bank: ______________________________

e. Intermediary Bank (if applicable): ______________________________

Other reimbursement methods available in the portal. Log in and go to your "My Profile" page to choose from Check, Wire, and EFT (Electronic Funds Transfer).

1901 Ponce De Leon Blvd. • Coral Gables, FL 33134
Phone: + 1 (786) 667-4800 • Email: claims@pagroupco.com

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MEDICAL CLAIM FORM

ACCIDENT & HEALTH

AUTHORIZATION

In view of a smooth administration of the policy and/or settlement of the insurance claim, and only for that purpose, I hereby give specific and informed consent regarding the processing data concerning myself and/or the members of my family. I certify that the above information is to best of my knowledge and believe to be correct and true. The issuance of false claims, misleading information or the withholding of information related thereto is an offense punished by Law. The information provided on or attached to this form may be disclosed to other persons or entities for the purpose of processing this claim and performing medical insurance plan administration. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF THE INSURED FILING THE CLAIM

DATE SIGNED (MM/DD/YYYY)

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