

TravelGap Medical Reimbursement Form



Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

SEE REVERSE SIDE FOR REQUIRED AUTHORIZATION SIGNATURE AND INSTRUCTIONS

| PATIENT INFORMATION | | | | INSURED INFORMATION (on ID Card) | | |
|--|--|---|--|----------------------------------|------------------------------|--|
| NAME: Family Name | | Given Name | | Certificate Number: | Product Name: | |
| Birth Date MM DD YY | | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Relationship to Insured member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | NAME: Family Name Given Name | |
| Does The Patient Have Other Health Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Reimbursement Mailing Address: | | |
| Name of Other Health Insurance Company: | | | | | | |
| Policy Number | | | | Contact Phone Number: | Email Address: | |

TO BE COMPLETED BY THE INSURED

Please indicate the dates of your travel/trip: Trip Start Date: _____ Trip End Date: _____

Please Describe your Accident or Sickness in the space provided below:

Was this medical expense the result of a **motor vehicle accident**? Yes No

If YES, are you aware of any **pending legal action** relating to this accident? Yes No

Was this condition or injury the result of or caused by the patient's **participation in a sport**? Yes No

Was this medical expense the result of a **work related illness/injury**? Yes No

Have you been **treated for the same condition** within the last 24 months? Yes No

If yes, indicate date treatment began and date you were last treated: Began Treatment on: _____ Last Treatment Date: _____

MEDICAL INFORMATION

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

| Date of Service (Mo/Day/Yr) | Country/City (where the service provider was located) | Provider of Service (Name of Hospital Doctor, Lab, etc.) | Service Rendered (Office Visit, X-ray, Prescription, etc.) | Illness or Diagnosis | Total (Please Indicate Currency) |
|--------------------------------|--|---|---|----------------------|-------------------------------------|
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GRAND TOTAL

PAYMENT INFORMATION

Payment Method: (check one) **Check** (payable in US\$ and mailed to the address indicated above) **Pay the Provider Directly**

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

X _____
Signature of Insured Member

Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Normally, providers of health care will bill us directly for services to you and your enrolled dependents. This is the preferred procedure.

When your health care provider bills us, you do not need to send us a claim form. If a physician, ambulance company or other provider sends their bill directly to you, or if you paid for the services yourself and you want to be reimbursed, we have no way of knowing about your claim until we have received your bill at HTH Worldwide. This Member Claim Form was developed for you to notify us of any covered health services for which we have not already been billed.

Please read the following instructions about how to report health care services.

Bills must be itemized: Canceled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

Each itemized bill must include: Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), Name of patient, Date(s) of service, Amount charged for each service, Total Charge, Diagnosis or reason for treatment

In addition, the following information must also be included on bills for the service types listed below:

- **Registered and Licensed Vocational Nursing Services:** Hours and dates of service; Location of service (residence or name of hospital); Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)
- **Ambulance:** Pick-up and delivery points; Number of miles
- **Anesthesia:** Start Time; End Time; Surgical procedure; Surgeon Name and address
- **Prosthetic Devices, Appliances or Durable Medical Equipment:** Doctor's orders or prescriptions; Purchase price
- **Outpatient Prescription Drugs:** Duplicate pharmacy generated receipt (not register tape) - must include Rx Number; Date Filled, Medication Name, Form, Strength and Quantity (NOTE: All Prescription Drug charges will be reimbursed to the insured person only)

SEND COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION TO:

HTH Worldwide
International Claims Department
One Radnor Corporate Center, Suite 100
Radnor, PA 19087

HTH Worldwide
Fax: 1.610.482.9623
Email – hthclaims@hthworldwide.com