Medical Reimbursement Form

HTH Worldwide

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:	Group Name:
Birth Date MM / DD / YY	Gender	Relationship to Insured member	NAME: Family Name Given Name	
	☐ M ☐ F	☐ Self ☐ Son* ☐ Spouse ☐ Daughter*	Reimbursement Mailing Address:	
Does The Patient Have Other Health Insurance Coverage? ☐ Yes ☐ No				
Name of Other Health Insurance Company:				
Policy Number			Contact Phone Number:	Email Address:

* If your son or daughter are age 19 or older, please attach proof of their enrollment as a full time college or university student

TO BE COMPLETED BY THE INSURED

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)	Provider of Service (Name of Doctor, Lab, Ambulance Company, etc.)	Service Rendered (Office Visit, X-ray, Prescription, etc.)	Illness or Diagnosis	Total (Please Indicate Currency)
			GRAND TOTAL	

PAYMENT INFORMATION

Payment Method: (check one) ☐ **Check** (payable in US$ and mailed to the address indicated above) ☐ **Wire Transfer** (bank information below) ☐ **Pay the Provider Directly**

Note: In order for HTH Worldwide to wire funds for reimbursement of claims, complete, accurate and legible information must be provided below. Funds will be wired in the currency in which it is billed, or another currency, if available*. If the billed currency is not available for wire transfer, funds will be wired in US Dollars.

Bank Name:		Bank ABA Number / SWIFT Code:	
Bank Address:			
Account Holder Name:		Bank Account Number:	
Currency Type:			

*Current available currencies are(subject to change): Australian Dollar, Canadian Dollar, Swiss Franc, Czech Koruna, Danish Kroner, Euro, Fiji Dollar, British Pound, Hong Kong Dollar, Hungarian Forint, Indian Rupee, Japanese Yen, Kuwaiti Dinar, Mexican Peso, Norwegian Kroner, New Zealand Dollar, Papua New Guinea Kina, Philippine Peso, Polish Zloty, Saudi Arabian Riyal, Swedish Kroner, Singapore Dollar, Slovak Koruna, South African Rand, Taiwan Dollar, Thai Bhat, Venezuelan Bolivar

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.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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

In 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.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Applicants applying for accident and health insurance in 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 five thousand dollars and the stated value of the claim for each such violation.

In 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.

In Kentucky and 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.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X _____ _____

Signature of Insured Member | Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

If you receive medical care at an HTH Provider, in most instances, they have agreed to bill HTH directly. When your health care provider bills us, you do not need to send us a claim form. However, some providers will not direct bill US Health Insurance companies. If that is the case, you must pay in advance for your medical expense and submit a claim for reimbursement. Please read the following instructions about how to report health care services received outside of the United States and how you can get reimbursed for your covered expenses.

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 COMPLETE CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO:

HTH Worldwide Insurance Services
Attn: International Claims Department
One Radnor Corporate Center, Suite 100
Radnor, PA 19087 USA
Fax: 1.610.293.3529
Email: hthclaims@hthworldwide.com