Claim Form

REGENT International

FOR OFFICE USE ONLY			
Claim No.			
CO-INSURANCE		DEDUCTIBLE	

I-PRINCIPAL INSURED NFORMATION

Full Name:	Name(s) Last Name	Policy Number	Date of Birth (MM/DD/YYYY) / /
Residential Address:	Street City State Country Zip Code		
Email Address:		Residential Telephone:	Cellular Number:

II-PATIENT INFORMATION (If different than Principal Insured)

Full Name:	Name(s) Last Name		Date of Birth (MM/DD/YYYY) / /
Residential Address: (if different than the Principal Insured)	Street City State Country Zip Code		
Email Address:		Residential Telephone:	Celullar Number:
Full Name of the Primary Physician and Specialty (Internist, Pediatrician, Gynecologist, etc.)			

III- ADDITIONAL INSURANGE COVERAGE

Does the patient have other health insurance or similar policy in force? [ ] Yes [ ] No

Has the patient requested, or will request reimbursement of expenses for this event through another insurance company, entity or plan? [ ] Yes [ ] No

Amount of reimbursement requested:	Name of insurance company, entity or plan:	Policy Number:

IV-PHYSICIAN INFORMATION

Full Name:	Name(s) Last Name	Specialty:	
Address:	Street City State Country Zip Code		
Email Address:		Telephone:	Fax:

V- CASE DATA

Event Type: [ ] Illness [ ] Treatment [ ] Accident [ ] Maternity [ ] Hospitalization [ ] Other: _____

Diagnosis or Symptoms:	Description of the treatment, procedure or surgery:	Date of Service (MM/DD/YYYY) / /

Place were services were rendered to the patient: [ ] Doctor's Office {] Laboratory [ ] Emergency Room [ ] Hospital [ ] Other:

Name of Hospital or Clinic:	Address:	Telephone Number:

VI- IN CASE OF ILLNESS

Has the patient previously suffered from this condition, or has experienced similar symptoms? [ ] Yes [ ] No

Has this patient previously required medical attention, or has been hospitalized for this condition or as a result of? [ ] Yes [ ] No

Date of First Symptom (MM/DD/YYYY): / /

VII- PHYSICIAN STATEMENT (if they have completed this form)

I hereby certify that the information provided in this claim form is accurate and complete.

Physician's Signature	Medical License Number	Date (MM/DD/YYYY) / /