Global
CLAIMS ADMINISTRATION

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FORMULARIO DE RECLAMACION AL SEGURO POR ACCIDENTE & ENFERMEDAD

GRUPO:_____ **NUMERO DE POLIZA:** _____ **FECHA:**_____

Nombre _____ Género (circule uno) **Masculino o Femenino** Fecha de Nacimiento_____

Domicilio Actual_____
Número y Calle Ciudad Estado Código Postal Número de Teléfono

Nombre del Dependiente _____ Fecha de Nacimiento_____

1. Fecha de la lesión o del comienzo de la enfermedad _____
2. ¿Cuándo fue consultado un médico por primera vez? _____
3. Está la lesión relacionada con el trabajo? ❑ Sí ❑ No ¿Se debe la lesión a un accidente automovilístico? ❑ Sí ❑ No
4. Si hay lesión, describa cómo y dónde acurrió el accidente
   _____
5. Naturaleza de la lesión o enfermedad _____
6. Haga una lista de todos los medicamentos prescritos por esta lesión/enfermedad_____
7. ¿Ocurrió la lesion mientras practicaba o jugaba un deporte? ❑ Sí ❑ No
   Si sí, por favor chequee uno de los siguientes: ❑ Intramural/Club Nombre del Deporte
   _____
   ❑ Otro_____ ❑ Intercolegial Firma del Entrenador Atlético _____
8. Ha sufrido usted una condición similar antes? ❑ Sí ❑ No Si sí, y usted fue tratado/a previamente, fechas en que fue tratado/a:_____
   _____
   Nombre y dirección del médico que lo/a trató:_____
9. Si hospitalizado/a en ese momento, fecha en que estuvo confinado/a al hospital:_____
   Nombre y dirección del hospital:_____

¿Tiene otro seguro que cubra su condición (grupo, individual, automóvil, médico, o responsabilidad? ❑ Sí ❑ No

Si sí, quién es el asegurado? ❑ Usted ❑ Padre/Madre ❑ Esposo/Esposa Dé el nombre de la Compañía_____

Si está cubierto/a bajo el seguro de su Padre/Madre/ Esposo/Esposa o si está asegurado/a privadamente, por favor, incluya la siguiente información:

Póliza #:_____ Grupo #:_____ Número de Teléfono de la Compañía de Seguro:_____

Nombre del Padre/Madre.Esposo/Esposa (Asegurado/a) _____ Seguro Social #_____

Nombre y Dirección del Empleador_____

ASIGNACION DE BENEFICIOS:

SE PAGARA A LOS PROVEEDORES DE SERVICIO (HOSPITAL, MEDICO, Y OTROS), A MENOS QUE UN RECIBO DE PAGO O ESTADO DE CUENTA ACOMPAÑE A LA CUENTA EN EL MOMENTO EN QUE SE SOMETA LA RECLAMACION.

IMPORTANTE: ESTE FORMULARIO TIENE QUE SER COMPLETADO Y DEVUELTO A LA COMPAÑIA DENTRO DE 90 DIAS DE LA FECHA DEL TRATAMIENTO ACOMPAÑADO POR TODAS LAS CUENTAS INCURRIDAS HASTA ESA FECHA. POR FAVOR ADJUNTE LAS CUENTAS DETALLADAS .
AUTORIZACION: Por la presente, yo autorizo a Global Claims Administration, o a su representante, para inspeccionar o asegurar copias de los récords de la historia del caso, reportes de laboratorio, diagnósticos, pronósticos, rayos-x, y cualquier otra información cubriendo ésta reclusión y / o previas reclusiones y/o discapacidades.
Una copia fotostática de esta autorización debe ser considerada tan efectiva y válida como el original.

FIRMA DEL PADRE/DE LA MADRE O DEL SOLICITANTE_____**FECHA**_____

NOTICIA IMPORTANTE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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 fines and confinement in prison

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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

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.

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

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

KANSAS: A “fraudulent insurance act” means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY:

Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Claim Form: 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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose 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 RSA 638:20.

NEW JERSEY:
Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Claim Form: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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.

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: 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.

OREGON:
IMPORTANT NOTE: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: 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 benefit.

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.

VIRGINIA: 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.

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.

NEW YORK FRAUD WARNING: 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.

CÓMO PRESENTAR UN RECLAMO

Siga estas instrucciones:

- Completar el frente del formulario de reclamo, en su totalidad;
- Firmar la Autorización Médica y la Autorización para Pagar Beneficios al frente del formulario de reclamo;
- Enviar por correo al Administrador con facturas detalladas, mostrando el diagnóstico y la Explicación de beneficios de su compañía de seguros principal para cada factura (si corresponde)

Todas las facturas detalladas deben incluir:

1. Nombre del paciente;
2. Dirección del paciente;
3. Diagnóstico (CIE10);
4. Fecha de Servicio;
5. Descripción del Servicio (Codificación CPT);
6. Nombre, dirección, número de teléfono y número de identificación fiscal federal del proveedor médico
7. Notas de consultorio del médico remitente/ordenante si están relacionadas con COVID19
8. Copia del pasaporte válido

- Se debe presentar un formulario de reclamo completo por cada lesión o enfermedad que sufra un estudiante.

Guarde copias de todos los formularios de reclamaciones, facturas y correspondencia para sus propios registros.
Para que se paguen los beneficios, los formularios de reclamo deben presentarse dentro de los 90 días posteriores a la fecha de la lesión o enfermedad.