Disability Management Services, Inc.

A third party administrator for:

Certain Underwriters at Lloyd's, London

1350 Main Street, Suite 1600 Springfield, MA 01103-1641 Tel: (413) 747-0990 or (844) 304-3550 Fax: (844) 611-4719

Medical Reimbursement Claimant's Statement

COMPLETE BOTH PAGES OF THIS FORM IN FULL AND RETURN WITH ANY STATEMENTS, RECIEPTS, OR EOB

1) NAME OF INSURED PERSON:

NAME OF CERTIFICATE OWNER/if different from insured:

2) SOCIAL SECURITY NO.:

3) POLICY NUMBER(S):

4) DATE OF BIRTH:

5) HOME TELEPHONE NO.:
WORK TELEPHONE NO:
CELL NO:

6) RESIDENCE (Street, Town/City, State, Zip): ☐ CHECK IF NEW ADDRESS.

Email address:

7) NATURE OF ILLNESS OR INJURY: (If more than one illness/injury please list separately)

8) HAS INSURED EVER HAD SAME OR SIMILAR CONDITION?

____ YES ____ NO

IF YES, DESCRIBE:

9) IF ILLNESS, WHEN DID SYMPTOMS FIRST APPEAR?

10) DATE OF FIRST TREATMENT FOR THIS CONDITION:

11) IF ACCIDENT, WORK-RELATED?

____ YES ____ NO

12) IF ACCIDENT, MOTOR VEHICLE RELATED?

____ YES ____ NO

13) IF ACCIDENT, PROVIDE DATE OF ACCIDENT, DESCRIBE WHERE (city/state/country) AND HOW ACCIDENT HAPPENED:

14) IS A WORKERS' COMPENSATION, AUTO, THIRD PARTY OR PERSONAL INJURY CLAIM BEING MADE? ____ YES ____ NO

IF YES, PLEASE INDICATE CARRIER'S NAME AND ADDRESS, ALONG WITH POLICY # AND/OR CLAIM #:

15) LIST ALL OTHER COMPANIES WITH WHICH INSURED HAS MEDICAL COVERAGE INCLUDING CARE RECEIVED UNDER VETERAN'S ADMINISTRATION:

COMPANY:	POLICY NUMBER:	COVERAGE TYPE:

Please continue to complete this form on page 2.

16) COMPLETE IF SUBMITTING ADDITIONAL REIMBURSEMENT REQUESTS:

PLEASE ATTACH ITEMIZED STATEMENT(S)/RECEIPTS OF EXPENSES PAID BY YOU AND EOB OF MEDICAL EXPENSES PAID BY OTHER HEALTH COVERA

DATE:	TYPE: (RX, EXAM, ETC)	PROVIDER:	COST:	OTHER COVERAGE:	TOTAL REQUESTED:

17) NAME OF TREATING PHYSICIANS:

NAME:	ADDRESS:	TELEPHONE:	DATES OF SERVICE:

18) NAME OF ALL HOSPITALS:

NAME:	ADDRESS:	TELEPHONE:	DATES OF SERVICE:

For your protection, laws in certain jurisdictions require the following to appear on this form:

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

I have read the foregoing and above answers are true and complete to the best of my knowledge and belief.

X ______________________________ ____________________ ____________________

SIGNATURE (Patient, or parent if minor) Relationship to insured DATE

PLEASE REMEMBER TO ATTACH ITEMIZED STATEMENTS OF EXPENSES PAID BY YOU, IF APPLICABLE (BILLS, RECEIPTS, INVOICES, ETC) ALONG WITH DOCUMENTATION (EOB) OF YOUR MEDICAL EXPENSES PAID BY OTHER HEALTH BENEFIT COVERAGE (MEDICAL, AUTO, WORKERS COMPENSATION, VETERANS ADMINISTRATION, THIRD PARTY PAYOR).