CLAIM FORM

HDI Group Name: _____

Policy/AETNA ID Number: _____

Please send your claim to:
Global Excel Management
PO BOX 10 Beebe Plain, VT 05823
Or by email: HDI-Specialty@globalexcel.com
Please submit any supporting documents with your claim: Itemized bill or treatment, payment receipt, medical notes, prescription, etc.

SECTION A PATIENT/CLAIMANT INFORMATION

Last name:	**First name**:	**Date of Birth** (MM-DD-YY)
Address:		Apt:
City:	State:	Zip code:
Telephone:	Email:	
Home country family doctor (if applicable):		Telephone:
Same address to send reimbursement check?		
Is this a reimbursement request as a result of an accident? if yes check appropriate box: ☐ Work ☐ Car ☐ Other		
If Work: Provide employer name:		Telephone:
If Car Accident, Provide insuarance name of car involved:		Telephone:
Car insurance Policy # or claim #:		

SECTION B OTHER INSURANCE

Do you have any other group or individual coverage? ☐ Yes ☐ No		
If yes, provide following details:		
Name of insurance company:		
Effective date:	Policy or ID # :	Telephone:

SECTION C CLAIM DETAILS

Amount Paid:	Provider Name	Telephone:	Type of services or treatment received (consultation, urgent care, etc.)	Chief complaint/Reason for treatment

SECTION D OTHER

Did you contact us prior to receiving treatment? Yes ☐ No ☐

SECTION E AUTHORIZATION AND RELEASE

1- I assign to Global Excel Management any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management for my claims submitted by Global Excel Management. with regard to these losses and to exchange information that facilitates this process.

2- I authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management authorized representatives of the Insurer. I further consent to the disclosure of this information Global Excel Management to other sources as may be required to obtain benefits from other sources.

3- I warrant that neither I nor any insured person have any additional coverage through any other insurer (other than that listed above).

4- I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim

Patient's Signature or Authorized Person Signature:_____ Date: _____