

# DavidShield Global International Claim Form/Member



## General Information

The International Claim Form must be completed for each patient in full, and accompanied by fully itemized bills. Submission of this form or its receipt by the company does not indicate recognition of any liability on behalf of the company or the relinquishment of any clauses in the insurance contract. Any person who, consciously and/or intentionally attempts to damage, deceive or defraud an insurance company or any other person, submitting a claim declaration containing false, incomplete or misleading information, may be found guilty of the attempt to defraud an insurance company and may be subject to a criminal suit and civil penalties. Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

### Instructions:

1. Complete the member information below.
2. Ask your physician to complete the attached information on the reverse side of this form.
3. Send the completed, signed form including any relevant medical documents and original receipts to DavidShield in the enclosed self addressed envelope.

Note: Please ensure that all the information is complete. Incomplete claim forms will delay payment\*

## 1. Patient Information

- 1A. Policy number (Copy this from your DavidShield identification card):  1B. Primary policy holder name \_\_\_\_\_  
\_\_\_\_\_  
1C. Patient name (First, Last) \_\_\_\_\_ 1D. Patient relationship (self, spouse, child) \_\_\_\_\_ 1E. Patient date of birth (mm/dd/yy) \_\_\_\_\_  
1F. Patient sex:  Male  Female \_\_\_\_\_ 1G. Patient current mailing address (Street, City and Country) \_\_\_\_\_  
1H. Other Health Insurance - Is the patient covered under other health insurance?  Yes  No If yes, please complete the following:  
Name of insuring company \_\_\_\_\_ Termination date (mm/dd/yy) \_\_\_\_\_  
Policy or identification number of other coverage

## 2. Claim Details

- 2A. Describe illness, injury, or symptoms requiring treatment \_\_\_\_\_  
\_\_\_\_\_  
2B. Medical treatment received \_\_\_\_\_ Date of service \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
2C. When did the first symptom of this condition begin? State the exact date if possible (mm/dd/yy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
2D. Have you ever had or been treated for this type of injury or illness before?  Yes  No  
2E. Are you currently taking prescription medication?  Yes  No If yes, please specify: \_\_\_\_\_  
2F. Is this condition the result of  Accident  Illness? If due to an accident, please complete the following:  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of accident \_\_\_\_\_ Time of accident \_\_\_\_\_ Location:  Home  Auto  Work  Other \_\_\_\_\_  
2G. If the accident was caused by someone else, attach a statement describing the accident

## 3. Payment Information

 Please select one of the following payment options and provide the applicable details so that we can process your claim\*.

### 3A. Reimbursement

- Check in local currency at your address abroad  
Pay to the order of \_\_\_\_\_ Address abroad for sending the check \_\_\_\_\_  
 Direct deposit at a local bank  
Bank Name \_\_\_\_\_ Account # \_\_\_\_\_ Swift Code \_\_\_\_\_  
Bank Address \_\_\_\_\_ Currency \_\_\_\_\_ Name on account \_\_\_\_\_  
 Direct deposit at a bank in Israel  
Bank Name \_\_\_\_\_ Bank # \_\_\_\_\_ Branch # \_\_\_\_\_ Account # \_\_\_\_\_ Name on account \_\_\_\_\_

### 3B. Direct payment to provider (hospital, doctor). Please complete and sign.

Authorization for assignment of benefits

I, the undersigned, authorize and request DavidShield to make payment for benefits due herein to:

Name of provider \_\_\_\_\_ Member signature \_\_\_\_\_

## 4. Signature

\* This form is not a determination of eligibility or a guarantee of payment. The patient must have been enrolled and eligible for benefits on the date that services were rendered. Additionally, coverage and payment are subject to limitations, exclusions and other specific terms of your DavidShield policy.

I hereby confirm that, to the best of my knowledge, the information provided is correct.

Patient name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# International Claim Form / Provider



## General Information

Please fill in the information below and attach an itemized bill containing at least the following information:

- Patient name (First, Last)
- Date of service
- Diagnosis and description of service
- Amount charged

### 1. Patient Information

1A. Policy number (Copy this from the DavidShield identification card):

/  /   
1B. Patient name (First, Last) 1C. Patient date of birth (mm/dd/yy) 1D. Patient sex:  Male  Female

1E. Patient current mailing address (Street, city and country)

### 2. Provider Information

2A. Provider name (First, Last) 2B. Specialty/Type of Provider

2C. License no. 2D. Address (Street, city and country)

2E. Telephone no.

### 3. Claim Details

3A. Is patient's condition:  Acute  Chronic  Accident  Work related

3B. Place of service:  Clinic  Hospital inpatient  Hospital outpatient  E.R.  Lab

3C. Date of service  /  /

3D. Describe the condition for which the patient received treatment, supplies or medication. Please list all symptoms:

3E. Diagnosis (description)

3F. ICD9 and / or CPT code if available CPT      ICD9    .

3G. Treatment received including prescriptions:

3H. Past medical history of current illness:

3I. Recommendation for continuing treatment:

### 4. Payment Information

4A. Total charges

4B. Payment received from member  4C. Amount due

4D. Will you accept direct assignment of benefits?  Yes  No. If yes, please choose

Check in local currency  Direct deposit at a local bank

Bank Name  Account #  Swift Code

Bank Address  Currency  Name on account

### 5. Signature

Provider Signature  Date