Cultural Insurance Services International - Claim Form

Policy number _____

Please fill in your policy number.

Instructions

- ❑ Complete and sign the medical claim form, indicating whether the doctor/Hospital has been paid.
- ❑ Attach original itemized bills for all amounts being claimed. No reimbursement will be considered for medical expenses not accompanied by original bills. When reimbursement of an expense is approved, it will be made to the provider of the service unless the bill is noted as having been paid by you. Payment will be in U.S. dollars unless otherwise requested.
- ❑ If payment is to be made to the provider of the service, the provider's name, address, telephone number and taxpayer identification number (if the provider is in the U.S.) must be included on the bill. If payment is to you, it will be mailed to your U.S. address unless otherwise requested.
- ❑ **Submit form and attachments to Cultural Insurance Services International, 1 High Ridge Park, Stamford, CT 06905. For claim submission questions, call (203) 399-5130 or e-mail cisiwebadmin@culturalinsurance.com.**

Name _____ Date of birth _____/_____/_____

U.S. address _____

Overseas address _____ Country _____

E-mail address _____

Phone (_____)_____ Expected departure date to your home country. _____/_____/_____

Date/place/time/description of injury/Sickness/Accident _____

Attach itemized bills for all amounts being claimed

_____

_____

Have these doctor/Hospital bills been paid by you? ☐ yes ☐ no

I authorize payment to provider of service for medical services claimed. ☐ yes ☐ no

I hereby authorize any insurance company, Hospital or Physician to release all information which may have a bearing on benefits payable under this plan. I certify the information furnished by me in support of this claim is true and correct.

Signature _____ Date _____/_____/_____

Cultural Insurance Services International - Claim Form

Policy number _____

Please fill in your policy number.

Instructions

- ❑ Complete and sign the medical claim form, indicating whether the doctor/Hospital has been paid.
- ❑ Attach original itemized bills for all amounts being claimed. No reimbursement will be considered for medical expenses not accompanied by original bills. When reimbursement of an expense is approved, it will be made to the provider of the service unless the bill is noted as having been paid by you. Payment will be in U.S. dollars unless otherwise requested.
- ❑ If payment is to be made to the provider of the service, the provider's name, address, telephone number and taxpayer identification number (if the provider is in the U.S.) must be included on the bill. If payment is to you, it will be mailed to your U.S. address unless otherwise requested.
- ❑ **Submit form and attachments to Cultural Insurance Services International, 1 High Ridge Park, Stamford, CT 06905. For claim submission questions, call (203) 399-5130 or e-mail cisiwebadmin@culturalinsurance.com.**

Name _____ Date of birth _____/_____/_____

U.S. address _____

Overseas address _____ Country _____

E-mail address _____

Phone (_____)_____ Expected departure date to your home country. _____/_____/_____

Date/place/time/description of injury/Sickness/Accident _____

Attach itemized bills for all amounts being claimed

_____

_____

Have these doctor/Hospital bills been paid by you? ❑ yes ❑ no

I authorize payment to provider of service for medical services claimed. ❑ yes ❑ no

I hereby authorize any insurance company, Hospital or Physician to release all information which may have a bearing on benefits payable under this plan. I certify the information furnished by me in support of this claim is true and correct.

Signature _____ Date _____/_____/_____