MEMBER REIMBURSEMENT CLAIM FORM

Please send your claims via email to: Reimbursements-AtlasMofa@globalexcel.com

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

SECTION A	PATIENT/CLAIMANT INFORMATION	
Last name:	First name:	Date of Birth (Month-Date-Year)
Complete Address:		Apt:
City:	State:	Zip code:
Seguros Atlas Policy or ID #:	Policy holder/Primary Insured:	
Telephone(s):	Email:	

SECTION B	CLAIM DETAILS				
Date of Treatment:	**Provider Name:**	**Telephone:**	**Type of services or treatment received (OFFICE CONSULT, Urgent Care, Prescription medication, Labs, etc)**	**Diagnosis/complaint:**	**Paid Amount USD**

SECTION C	OTHER INSURANCE		
Do you have any other group or individual coverage? Please circle: YES NO			
If yes, provide following details, Name of Insurance company name:			
Policy or ID #:	Effective Date:	Telephone:	
If Car accident, provide insurance name of car involved:		Car Ins Policy #:	Telephone #

SECTION D 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 to 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

5- I understand that my claim will be reviewed and reimbursed according to the terms and conditions of my policy (exclusions, copayments, deductibles, etc. may apply)

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

- **Please note that all reimbursements will be payable by check and sent to the address provided on SECTION A**
- **All request must include the medical report**
- **All request must include copies of the payments receipts**