Claim Form

Please complete Parts 1,2,3,4, and 5, if applicable.
Mail all claim forms and **all original itemized bills** for services and supplies to:

Korak Healthsource, Inc. c/o
Azimuth Risk Solutions, LLC
P. O. Box 206
Forest Hill, MD 21050

Website: www.azimuthrisk.com
E-mail: service@azimuthrisk.com
Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851

For any additional questions or concerns please contact us via e-mail, fax, or phone.

Part 1 Please complete claim form below. All communications of this claim will be sent to the address below.
Is this claim related to (please check one):
❑**Accident Related Injury** ❑ **Dental Accident** ❑ **Illness/Injury**

Claimant/Patient Name:		**Policy holder's Name:**		
Date of Birth: M/D/Y	❑Male ❑Female	**Date of Birth: M/D/Y**		❑Male ❑Female
Complete Mailing Address for all correspondence:		**City, State:**	**Country:**	**Postal Code:**
Email:	**Telephone:**		**Work Telephone:**	
Destination Country(ies):				
Identification Number:	**Citizenship of Claimant:**		**Home Country:**	
Full-Time Student: ❑Yes ❑No				
If yes, please provide the name and address of the school:				
Is this a continuing claim? Please check here: ❑Yes ❑No If yes, please provide original dates of the initial claim form sent:				

Part 2 If covered by another insurance plan please complete below.	
Do you have additional Insurance? ❑Yes ❑No	
Name of Primary Insured of other insurance company:	Date of Birth: **M/D/Y**
Please provide name of other insurance company:	
Mailing address of other insurance company:	
Policy Number of other insurance plan:	Group Number of other insurance plan:

Part 3 Please fill out all applicable questions below, more information may be requested. (If you need additional space, please attach a separate sheet.)

1. **How did this condition/illness begin?**
   Please describe all symptoms.

2. **When did the first symptom of the illness/condition begin? (M/D/Y)**

3. **Have you ever been treated for this illness/condition before? ❑Yes ❑No**

4. **List all the names and addresses of the providers you have seen for this illness/condition:**

5. **Is this illness/condition the result of an accident? ❑Yes ❑No**

6. **Is this illness/condition related to a work accident? ❑Yes ❑No**
   If yes, have you applied for workers compensation? ❑Yes ❑No

7. **Did this illness/condition involve a motor vehicle? ❑Yes ❑No**
   If yes, please provide names of all parties involved, including insurance carriers and policy numbers including the dates of accident:

8. **Was a police report filed? ❑Yes ❑No**
   If yes, Name and Number of Police Department, and number of report:

Part 4 Please complete only if treatments occurred outside of the US.

Country which treatment occurred in?	Condition(s)/Diagnosis	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment	Total Charge paid/billed?	Type of currency paid/billed?

Part 5 Authorization, please complete for all claims.

I verify all information contained in this form is true, correct and complete to the best of my knowledge.

The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition of any family member listed on this Application to release said information to Azimuth Risk Solutions, LLC.

Notice: Any false statement, concealment or fraud shall render this insurance null and void and claims hereunder shall be forfeited.

Authorization: I authorize payment of medical benefits to the doctor or other supplier of services submitting the **attached bills**.

Print Name of Primary Insured_____**Date (Mo./Day/Yr.)**

Signature of Insured,
Or Guardian_____**Date (Mo./Day/Yr.)**