PRE-CERTIFICATION PROVISIONS & REQUIREMENTS

Pre-certification is a general determination of Medical Eligibility, only, and all such determinations are made by Azimuth Risk Solutions, LLC "Azimuth" (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Participating Member and/or his/her relatives, guardians and/or healthcare providers at the time of Pre-certification. Azimuth reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-certification is **not** an assurance, authorization, or verification of coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-certified by Azimuth does not guarantee the payment of benefits or the amount or eligibility of benefits. Azimuth's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all Terms and Conditions of the Master Policy and/or the Evidence of Insurance, including exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations, and the requirement that claims be Usual, Reasonable and Customary. Also, any consideration or determination of a Pre-certification request shall not be deemed or considered as Azimuth's approval, authorization or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither Azimuth (nor anyone acting on their behalf) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Participating Member, or to make any diagnosis or medical Treatment decisions on behalf of the Participating Member, and all such decisions must be made solely and exclusively by the Participating Member and/or his/her family members or guardians, treating Physicians and other healthcare providers. If the Participating Member and his/her healthcare providers comply with the Pre-certification requirements of the Master Policy and/or the Evidence of Insurance, and the Treatment or supplies are Pre-certified as Medically Necessary, Azimuth will reimburse the Participating Member for Eligible Medical Expenses incurred in relation thereto, subject to all Terms of this insurance, including the Deductible and Coinsurance. Eligibility for and payment of benefits are subject to all of the Terms of this insurance.

PRE-CERTIFICATION REQUIREMENTS:

The following Treatment and/or supplies must always be Pre-certified for Medical Necessity by Azimuth:

- Inpatient Treatment of any kind; and
- Any Surgery or Surgical procedure; and
- Care in an Extended Care Facility; and
- Home Nursing Care generally; and
- Durable Medical Equipment; and
- Artificial limbs; and
- All Covered Transplant Treatment.
- Diagnostic testing such as MRI, CT Scan, or PET Scan

To comply with the Pre-certification requirements of this insurance for the Treatment and services listed in the Section above, the Participating Member or his/her Physician must:

Contact Azimuth at the telephone numbers printed on the ID card, as follows:

Inside the United States:	1-888-201-8850
Outside the United States:	1-317-644-6291 (Collect if necessary)
E-mail: service@azimuthrisk.com	Website: www.azimuthrisk.com

- As soon as possible before the Treatment is to be obtained; and
- For transplant Pre-certification, contact Azimuth as soon as possible but always within seventy-two
- (72) Hours of becoming a candidate for a Covered Transplant; and
- Comply with the instructions of Azimuth and submit any information or documents required by
- Azimuth; and
- Notify all Physicians, Hospitals and other healthcare providers that this insurance contains
- Pre-certification requirements and ask them to fully cooperate with Azimuth.

CLAIM FORM QUESTIONNAIRE

Please complete Parts 1,2,3,4, and 5, if applicable.
Mail, Fax, or email all claim forms, itemized bills and receipts of payment for services and supplies to:

Azimuth Risk Solutions, LLC
Attn: Claims Dept.
P.O. Box 627
Indianapolis, IN 46206

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

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 (as it appears on ID card):		**Policy holder's Name (as it appears on ID card):**	
Date of Birth: M/D/Y	☐Male ☐Female	**Date of Birth: M/D/Y**	☐Male ☐Female
Claimant/Patient's Relationship to Primary Insured: ☐Self ☐Spouse ☐Dependent Child ☐Other			
Complete Mailing Address for all correspondence:	**City, State:**	**Country:**	**Postal Code:**
Email:	**Telephone:**	**Work Telephone:**	
Destination Country(ies):			
Azimuth ID or Group Number:	**Citizenship of Claimant:**	**Home Country:**	
Are you a full-time student: ☐Yes ☐No			
If yes, please provide the name and address of the school:			

An Azimuth Claim Form will need to be submitted for each NEW illness/condition the member is being treated for.

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, though more information may be requested. (If you need additional space, please attach a separate sheet.)

1. **What medical condition/illness or injury are you being treated for? Please describe all symptoms.**

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

3. **Have you ever been treated for this illness/condition before?** ☐**Yes** ☐**No**
   If yes, please list the treatment dates and complete question #4.

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

5. **Is this illness/condition related to a work accident?** ☐**Yes** ☐**No**
   If yes, have you applied for workers compensation? ☐**Yes** ☐**No**
   Date of accident:

6. **Did your injury involve a motor vehicle accident?** ☐**Yes** ☐**No**
   If yes, please provide the name of all parties involved, insurance carriers and policy numbers, and the date of the accident:

7. **Was a police report filed?** ☐**Yes** ☐**No**
   If yes, please submit a copy of the police/accident report with this claim form.

Part 4 - Please complete this section if your treatments occurred outside of the US. List each treatment/claim separately.

Country which treatment occurred in:	Condition(s)/Diagnosis	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Dates(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 licensed doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or insurance benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition, or the financial or employment status 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.

Print Name of Primary Insured_____**Date (M/D/Y)** _____

Signature of Insured, or Guardian_____**Date (M/D/Y)**_____