



EXCLUSIVELY OFFERED THROUGH



**SCHOLARS CLAIM FORM**

**Please type or print. See the sheet of Instructions for use of your claims form.** Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help us to process your claim quickly and accurately.

PATIENT INFORMATION				INSURED INFORMATION (on ID Card)									
NAME Last			First			Middle			CERTIFICATE NUMBER		GROUP NAME		
BIRTH DATE		GENDER		RELATION TO SUBSCRIBER				NAME Last		First		Middle	
Month	Day	Year		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Daughter <input type="checkbox"/> Son					
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE?						MAILING ADDRESS							
<input type="checkbox"/> YES <input type="checkbox"/> NO													
NAME OF OTHER HEALTH INSURANCE COMPANY						CITY		STATE		ZIP CODE			
POLICY NUMBER						PHONE INSIDE U.S.		PHONE OUTSIDE U.S.		EMAIL			

**TO BE COMPLETED BY THE INSURED**

*Use this section to report any COVERED health service. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.*

Please Describe your Accident or Sickness in the space provided below: *If necessary, please use an additional sheet of paper.*

---



---

Was this medical expense the result of a motor vehicle accident?  YES  NO If yes, indicate date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

If YES, are you aware of any pending legal action relating to this accident?  YES  NO

Please provide the names and policy numbers of any automobile insurance policies held by you or any driver involved in this accident.

---

Was this condition or injury the result of or caused by the patient's participation in a sport?  YES  NO

Have you been treated for the same condition within the last 24 months?  YES  NO

If yes, indicate date treatment began and date you were last treated: Began: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_ Last: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

**Payment Information:**  Check  Wire transfer

Address to send check or Explanation of Benefits to: \_\_\_\_\_

Electronic Transfer Information: Currency\*? \_\_\_\_\_

Name of Bank \_\_\_\_\_ Bank ID# or ABA/Swift number \_\_\_\_\_

Name of Bank Account Holder \_\_\_\_\_ Bank Account Number \_\_\_\_\_

Bank location/address \_\_\_\_\_

\*Available currencies: Australian Dollar, Canadian Dollar, Swiss Franc, Czech Koruna, Danish Kroner, Euro, Fiji Dollar, British Pound, Hong Kong Dollar, Hungarian Forint, Indian Rupee, Japanese Yen, Kuwaiti Dinar, Mexican Peso, Norwegian Kroner, New Zealand Dollar, Papua New Guinea Kina, Philippine Peso, Polish Zloty, Saudi Arabian Riyal, Swedish Kroner, Singapore Dollar, Slovak Koruna, South African Rand, Thai Baht, Taiwan Dollar, United States Dollar, Venezuelan Bolivar



EXCLUSIVELY OFFERED THROUGH



**MEDICAL INFORMATION**

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Ambulance Company, etc.)	SERVICE RENDERED (Office Visit, X-ray, Prescription, etc.)	ILLNESS OR DIAGNOSIS	TOTAL (Please Indicate Currency)
<b>GRAND TOTAL</b>				

Please ensure that your remittance information is included on bill

**Certification and Release of Information Authorization:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. This claim will be returned if this claim form is not signed.

X \_\_\_\_\_ DATE  
 REQUIRED SIGNATURE OF SUBSCRIBER

**Payment Authorization:** I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them.

X \_\_\_\_\_ DATE  
 REQUIRED SIGNATURE OF SUBSCRIBER

SEND COMPLETE CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO ADDRESS BELOW

POWERED BY:



1.610.254.8765 (Collect Calls Accepted)  
 1.866.750.6125 (U.S. Toll Free)  
 1.215-793-6996 (Fax)



EXCLUSIVELY OFFERED THROUGH



**INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM**

**Dear Member:**

If you receive medical care at an HTH Direct Provider, in most instances, they have agreed to bill HTH directly. When your health care provider bills us, you do not need to send us a claim form. However, some providers outside of the United States will not direct bill US Health Insurance companies. If that is the case, you must pay in advance for your medical expense and submit a claim for reimbursement. Please read the following instructions about how to report health care services received outside of the United States and how you can get reimbursed for your covered expenses.

We are happy to serve you.

**PATIENT INFORMATION**

**INSURED INFORMATION (on ID Card)**

Use this section to identify the patient and policyholder. Some of this information may be found on your HTH Worldwide ID card.

**MEDICAL INFORMATION**

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, Ambulance Company, etc.)	SERVICE RENDERED (Office Visit, X-ray, Prescription, etc.)	ILLNESS OR DIAGNOSIS	TOTAL (Please Indicate Currency)
04/09/04	Jean Salzman, M.D.	Office Visit	Bronchitis	€35.00
04/11/04	Michael Ranier, MBBS.	X-ray	Strain	€57.00
<b>GRAND TOTAL</b>				€92.00

**THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THE SERVICE TYPES LISTED BELOW**

**REGISTERED AND LICENSED VOCATIONAL NURSING SERVICES**

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

**PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT**

- Doctor's orders or prescriptions
- Purchase price

**OUTPATIENT PRESCRIPTION DRUGS**

- NOTE: All Prescription Drug charges will be reimbursed to the insured person only
- Duplicate pharmacy generated receipt (not register tape)
- Must include Rx Number; Date Filled, Medication Name, Form, Strength & Quantity

**AMBULANCE**

- Pick-up and delivery points
- Number of miles

**ANESTHESIA**

- Start Time
- End Time
- Surgical procedure
- Surgeon Name and address

**BILLS MUST BE ITEMIZED**

Canceled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Date(s) of service
- Amount charged for each service
- Total Charge
- Diagnosis or reason for treatment

**SEND COMPLETE CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO ADDRESS BELOW**

POWERED BY:



1.610.254.8765 (Collect Calls Accepted)  
1.866.750.6125 (U.S. Toll Free)  
1.215-793-6996 (Fax)