TRIPLE-S VIDA

THE ADMINISTERING OF CHEMOTHERAPY AND RADIOTHERAPY CLAIM FORM

ASEGURADO

Insured Name				Social Security	Policy No.	
Last Name	Mother's Surname	Name	Inicial	/ /		
Patient Name				Social Security	Date of Birth	Sex
Last Name	Mother's Surname	Name	Inicial	/ /	/ / Month Day Year	❒ M ❒ F

Relationship	Phone Number	Cell Phone Number	E-mail

Postal Address	Urb., PO Box, HC, RR	Number ./ Street	City	Country	Zip Code

Residential Address	Urb., PO Box, HC, RR	Number ./ Street	City	Country	Zip Code

DESCRIBE IN DETAIL THE SERVICES

DATE			SERVICE CODE	AMOUNT OF SERVICES	DESCRIBE IN DETAIL THE SURGERY PROCEDURES, THE ADMINISTERING OF CHEMOTHERAPY AND RADIOTHERAPY	SERVICE CHARGE
MONTH	DAY	YEAR				

Diagnosis (Code Icd9/Icd10)

Name of the Health Care Provider	Phone Numbers	I certify that the medical services were provided by me or under my supervision
Address	Medical Expertise	
	NPI	
	Licences Num.	Physician or Health Care Provider Signature _____ Date _____

IMPORTANT NOTICE

"Any person who knowingly presents false information on an insurance application with the intention of committing fraud, or, who, presents, or helps presents, a fraudulent claim for the payment of a loss of other benefit, or presents more than one claim due to the same loss or damage, commits a severe offense and will be sanctioned for each offense with a penalty of not less than five thousand dollars ($5,000), and not more than ten thousand dollars ($10,000) or penalty of imprisonment for a term of three (3) years, or both penalties. If aggravating circumstances exist, the imprisonment penalty could be increased up to a maximum of five (5) years; if extenuating circumstances exist, the imprisonment penalty could be reduced to a minimum of two (2) years". Law 230 of august 9, 2008.

❒ I request payment only by check. I am cancelling any previous authorization for automatic deposit to my account.
❒ I am notifying that my bank account number has changed.

_____ Primary Insured Signature

_____ Date

DO YOU WANT TO RECEIVE FAST AND SECURE PAYMENTS?
Authorization for Electronic Payments to Claimants

Please provide a voided check or deposit slip.

I hereby AUTHORIZE Triple-S Vida to initiate credit entries to my account for the payable amount of the benefits claimed in the policy issued by Triple-S Vida, Inc., in which I am Policy Owner or Beneficiary. I should submit, in writing thirty (30) days in advance, the cancellation of this authorization or any change to the account information.

_____ Name and Branch of the Bank	_____ Route and Transit Number	_____ Bank Account Number
_____ Name of the Account Holder	_____ Account Type: ☐ Check ☐ Savings	_____ E-mail
_____ Authorized Signature	_____ Authorization Date	☐ I authorize Triple-S Vida, Inc., to send the payment notice to my email.

TRIPLE-S VIDA, INC.
PO BOX 363786 • SAN JUAN PR 00936-3786 • Tel. (787) 758-4888
reclamacionesindividual@sssvida.com