LRFA

PO Box 8857
Elkins Park, PA 19027

T 215.635.4137 / info@LRFA.org
F 215.635.1583 / www.LRFA.org

FOR LRFA USE ONLY
Benefits paid: $_____ Plan: _____
Approved by: _____ Date: _____

TRAVEL MEDICAL PLAN
Benefit Request Form

1. **Covered Person** Last Name First Name MI

2. LRFA Membership #

3. Certificate #

4. Coverage Effective Date (mm/dd/yyyy)

5. Termination Date

6. Date of arrival in Home Country (mm/dd/yyyy)

7. Date when accident/illness occurred (mm/dd/yyyy)

8. If accident, provide details on how, when and where the accident occurred

9. If illness, provide details on when and where symptoms first occurred and nature of illness

10. Name and address of consulting physician(s)

11. ☐YES ☐NO
Have you previously been treated for this illness? If yes, when?

12. Name, address and phone of your primary physician in your Home Country

13. Prescription medications you are presently taking

14. Other Health Insurance Coverage: include name of insurance carrier, address and policy number

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, government agency, group policy holder, insurance company, association, employer or benefit plan administrator to provide the LRFA or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of this benefit request and copies of all of that person's hospital and medical records, including information relating to mental illness and use of drugs and alcohol. I authorize the group policyholder, employer or benefit plan administrator to provide the LRFA with financial and employment-related information. I understand that this authorization is valid for the term of this Benefit Plan coverage and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that benefit claims are subject to coinsurance and deductibles.

Signature **Name** (please print)

PLEASE READ THE INFORMATION ON THE OTHER SIDE ⇨

BENEFIT REQUEST INFORMATION

1. All claims must be accompanied by:
   1) A "Benefit Request" form;
   2) Itemized statements/invoices/bills you receive from the provider of service;
   3) Explanation of Benefits from another insurance carrier, if applicable;
   4) A medical report with a detailed account of the illness, injury or loss sustained (provided by the physician or medical facility where treatment was received). The date, location and cause of the incident must be included.

2. All claim forms must be completed in full and signed by the LRFA member or representative.

3. The original documents or legible copies thereof is acceptable.

4. A hospital or physician's statement simply stating the amount/balance due is not acceptable.

5. Documents provided to the LRFA may be in English or Latvian.

6. The LRFA retains the right to contact physicians, hospitals or other medical providers to release records pertaining to a treated illness/injury.

7. Notice of the incident (accident/illness/loss) must be received by the LRFA within 30 days.

8. Benefit requests submitted more than 6 months after the date of the incident will be rejected.

9. Falsifying information will result in the refusal of benefits and or/dismissal from the enrollment in the LRFA coverage plan.

10. Forward all claims to:

LRFA
PO BOX 8857
ELKINS PARK, PA 19027