PRE-CERTIFICATION PROVISIONS & REQUIREMENTS

Pre-certification is a general determination of Medical Eligibility, only, and all such determinations are made by 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 this Master Policy, 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 this Master Policy, 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.

SPECIFIC REQUIREMENTS:

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

1. Inpatient Treatment of any kind; and
2. any Surgery or Surgical procedure; and
3. care in an Extended Care Facility; and
4. Home Nursing Care generally; and
5. Durable Medical Equipment; and
6. artificial limbs; and
7. all Covered Transplant Treatment.
8. Diagnostic testing such as MRI, CT Scan, PET Scan, and Ultrasounds

GENERAL REQUIREMENTS:

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

1. 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 **and**

2. As soon as possible before the Treatment is to be obtained; and
3. 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
4. Comply with the instructions of Azimuth and submit any information or documents required by Azimuth; and
5. 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

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:

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

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.)**