



CLAIM FORM

This form must be completely filled out and legible for the claim to be processed. Itemized, legible invoices must be submitted with the claim form. Incomplete claim submissions may delay claim processing. If you are utilizing Veterinarian Direct Pay, a Pre-Claim MUST be completed online prior to your visit, and a claim form is not needed.

Member Details

Date of Claim: _____

Member Name: _____ Phone #: _____

Member #: _____ Email Address: _____

Which Membership Do You Have: Premium Membership Accident and Illness Membership

Pet Details

If you have multiple pets enrolled, a separate claim form is required for each pet seen by the veterinarian today.

Pets Name: _____ Date of Birth (or Approx. Date): _____

Injury, Illness or Routine Care/Wellness Visit: Injury Illness Routine Care/Wellness Visit

Is this claim in reference to a Pre-existing Condition: Yes No

Claim Details

Reason For Treatment - If unsure, please contact your veterinarian for more information.

Hospital/Clinic Name: _____

Reason For Visit (symptoms): _____

(Additional Space On Back)

Date you first noticed symptoms: _____ Total Amount of Claim: \$ _____

Diagnosis: _____ Is a followup visit needed: Yes No

Diagnosis is the Medical Condition treated. Please do not list symptoms such as limping or vomiting. List those above in illness/injury. If this visit was for a Wellness Visit, write Wellness on the Diagnosis line.

Have you submitted a previous claim for this same Illness/Injury?: Yes - Claim #: _____ No

I confirm that all statements provided on this form are true and accurate to the best of my knowledge. I hereby give EZ Pet Check authorization to request any medical records or financial information for the pet referenced in this claim and approval to discuss the details of this claim with the treating veterinarian or their staff/authorized representative. I understand in the event I receive funds for a service that is not shareable through my Membership, I may be required to repay it. 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 prison.

Member/Co-Member Signature _____

Date _____

VETERINARIAN DIRECT PAY
FOR CLAIMS USING DIRECT PAY
A CLAIM FORM IS NOT REQUIRED
ADDITIONAL INFORMATION ON REVERSE SIDE



Additional Visit Details (If any)

Provider Details - Required For All Emergency Care Claims or Claims Over \$500.00

Must Be Completed by the care provider if your pet was seen for Emergency Care or if your claim total is over \$500.00. If this visit was not for Emergency Care or Over \$500.00, then you may skip this section.

Provider: This claim form is for a Member of the EZ Pet Check Cost-Sharing Network. They are filing a claim for either Emergency Care or care that is over \$500.00 in Routine Care. Please fill out the details below about this visit. You may return this form to the Member once completed or send it to EZ Pet Check using one of the methods below. **If your clinic would like to learn more about becoming a Participating Provider of our Network, visit www.ezpetcheck.com and click on Provider Corner.**

Hospital/Clinic Name: _____

Person Completing Form: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email/Phone (Preferred method of contact if we have questions): _____

Was this an After Hours Emergency Visit: Yes No Was this life-threatening in nature: Yes No

Is this Member a previous client to your clinic: Yes If yes, is this pet seen regularly: Yes No

Provider Authorization

I confirm to the best of my knowledge that all statements provided on this form are true and accurate. I understand and agree that EZ Pet Check, may and can contact this clinic in regards to this visit. I understand that by the Member completing this Claim Form and submitting it authorizes EZ Pet Check to receive any information about this visit. 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 prison.

Provider Signature

Date

COMPLETED CLAIM FORM AND ALL INVOICES CAN BE SUBMITTED TO



**242 W. MAIN ST #235
HENDERSONVILLE, TN 37075**



CLAIMS@EZPETCHECK.COM



(615) 991-8777

ALL CLAIMS MUST BE SUBMITTED WITHIN 10 DAYS OF THE VISIT FOR PROCESSING!