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. No claim form is needed if you are submitting your claim online and payment is going to the Member. For *Veterinarian Direct Pay,* the back side of this form must be completed and submitted by the Provider.

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)*: _____

_____

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

How is this claim being paid for: [ ] Member [ ] Veterinarian Direct Pay

Note: For *Veterinarian Direct Pay,* the provider ***MUST*** complete the backside of this form and submit it.

*You must be eligible for *Veterinarian Direct Pay* to be able to use it. Not all providers will accept *Veterinarian Direct Pay*.

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**

FOR CLAIMS USING VETERINARIAN DIRECT PAY
THE PROVIDER MUST COMPLETE THE BACKSIDE OF THIS FORM

Provider Details For Veterinarian Direct Pay

Must Be Completed And Submitted By The Provider If Payment Is Being Sent Directly To The Provider!

If you are already a Participating Provider, please enter your Participating Provider # below. Participating Providers do not need to fill out location details or banking information. If you would like to register as a Participating Provider, visit www.ezpetcheck.com and click on "Provider Corner."

Hospital/Clinic Name: _____

Participating Provider #: _____ Person Completing Form: _____

Address: _____

City: _____ State: _____ ZIP: _____

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

Attention Provider: If payment is to be sent directly to you, please ask the Member to see their Membership Card. After you have their card go to www.ezpetcheck.com and click on "Provider Corner" on the left-hand side of the screen, once in the Provider Corner, click on "Veterinarian Direct Pay - Verify A Member" and follow the simple instructions. This process takes 3-5 minutes. ***For Virtual Credit Card Payments, You must register as a Participating Provider to access a virtual card #. Virtual Card Numbers will be immediately available in your online Provider Account after you are registered.***

Payment Details

This Member has been verified, and the reimbursement portion of this claim will be sent directly to the Provider listed above.

⬜ **- Payment By Check** • Usually arrives in 5-7 Business Days • Payment will be mailed to the address above • Payment will be for Authorized Amount Only	⬜ **- Payment By Direct Deposit** • Usually deposited in 2-3 Business Days Bank Name: _____ Routing #: _____ Account #: _____
⬜ **- Payment Will Be Processed Today Using A Virtual Credit Card Assigned During Verification Online** • Payment is processed immediately through your Credit Card Processing Equipment • Virtual Credit Cards Must Be Processed As A Keyed Transaction • Must be a *Participating Provider* to access Virtual Credit Card Details - Registration is Free!	

Provider Authorization

I confirm to the best of my knowledge that all statements provided on this form are true and accurate. The Member has been verified and their Membership is valid. 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.

For Virtual Credit Card Processing: The amount entered for verification is accurate and the Virtual Credit Card # given has been charged for up to the authorized amount only. I understand that this verification is only valid for one (1) transaction and a separate verification must be completed for each additional transaction.

For Direct Deposit Payments: I confirm the Bank Name, Routing #, and Account # listed is correct. I certify that this account does belong to the provider listed on this claim form.

_____ _____

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

IF PAYMENT IS GOING DIRECTLY TO THE PROVIDER THEN THIS CLAIM MUST BE SUBMITTED BY THE PROVIDER!