



P.O. Box 88503  
Indianapolis, IN 46208-0503  
T: (866) 243-7524  
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## CERTIFICATE OF MEDICAL HISTORY

### REQUEST FOR MEDICAL RECORDS

(DATE) \_\_\_\_\_

\_\_\_\_\_ (PATIENT NAME)

\_\_\_\_\_ (PATIENT ADDRESS)

\_\_\_\_\_ (CITY, ST, ZIP)

**Note: The patient is responsible for any charges incurred for the completion of this form.**

Re: Travel Insurance Certificate No: \_\_\_\_\_

Date of Loss: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dear Dr: \_\_\_\_\_: (Name of all attending physicians)

We are in the process of evaluating a travel insurance claim for your patient named above. As part of the standard adjudication process for claims that involve medical situations, we have enclosed a request for the physician to provide us with copies of the medical records. We request all medical records and office notes on file for the dates of:

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

In addition to providing us with copies of the requested medical records, we also ask that you complete the attached Certificate of Medical History. The patient should have already signed the Patient Authorization statement on the Certificate. Your signature is required as verification that you have submitted all pertinent information, which will be used in the determination of the patient's claim.

Return the entire Certificate of Medical History, along with the requested medical records to:

iTravelInsured  
P.O. Box 88503  
Indianapolis, IN 46208-0503

## CERTIFICATE OF MEDICAL HISTORY

**Instructions: Failure to supply complete information will delay the claim process!**

1. Complete all information requested below. Both Physician and Patient must sign where indicated.
2. Send this in along with requested medical records.

### TO BE COMPLETED BY PATIENT

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Cancellation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize the release of the information requested below to iTravel. A photocopy of this request is just as valid as the original document.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### TO BE COMPLETED BY YOUR PHYSICIAN CERTIFYING YOUR CANCELLATION AND/OR TREATING YOUR ILLNESS, INJURY.

**Note: The patient is responsible for any charges incurred for the completion of this form.**

1. Nature of Illness/Injury? \_\_\_\_\_
2. Date symptoms first occur? \_\_\_\_/\_\_\_\_/\_\_\_\_ Is this a recurring illness? \_\_\_Yes \_\_\_No
3. Dates of treatment? From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Was patient also treated by anyone else? \_\_\_\_\_ If Yes, Who? \_\_\_\_\_
5. Has there been any change in current medications or was there newly prescribed medications? \_Yes\_No  
If yes, explain, including the date of the prescription:  
\_\_\_\_\_  
\_\_\_\_\_

6. State the reason why the patient is unable to travel. Please **attach supporting clinical information**:  
\_\_\_\_\_  
\_\_\_\_\_

7. Was this patient referred to any other physicians? \_\_\_Yes \_\_\_No If Yes, please provide their names: \_\_\_\_\_  
\_\_\_\_\_

I/We verify that the information, diagnoses, opinions and records submitted on behalf of the above named patient are true and accurate to the best of my/our knowledge, information and belief.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Telephone

\_\_\_\_\_  
Date

**Any person who knowingly and with intent to defraud any insurance company, provides materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, and may be subject to criminal and/or civil penalties. Another physician may review the information provided.**