Authorization for Reimbursement Form

I understand this consent form is to authorize payment of my medical benefits to the undersigned person(s) below. I will be responsible for paying all insurance co-pay and deductibles and unpaid balances by my insurance carrier to the Provider. Please understand that any circumstance where the Participating Member pays and provides proof of payment, we must reimburse the Participating Member.

Please complete the form below to authorize payment.

Claimant/Participating Member/Insured Name:		**Date of Service of your claim:**	
Date of Birth: M/D/Y	❑Male ❑Female	**Name of Provider where services were incurred:**	
Complete Mailing Address:		**City, State:**	**Postal Code:**
Email of Insured:		**Telephone Number of Insured:**	
Destination Country(ies):			
Identification Number/Group Number:	**Citizenship of Claimant:**	**Home Country:**	
Authorized Party to be reimbursed (last name, first name):			
Reimbursement to be mailed to this Street Address:	**City State:**	**Zip:**	
Insured Signature (consent for payment for all services to be reimbursed to the name provided below):		**Date:**	

Please Fax, Email, or Mail all **COMPLETED** forms for authorization of payment 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