



PRE-NOTIFICATION FORM

INFORMATION

Entire form must be completed and submitted by fax or e-mail.

Send claims to: Claria Life and Health 7491 W. Oakland Park Boulevard 2nd. floor. Tamarac, Florida 33319
Phone: (954)749-1025 Fax: (954)749-1027 Email: medical@claria.us

Please note: this is not a guarantee of payment

GENERAL INFORMATION

Main insured Name:		Main Insured Last name:	
Notifier's Name:			
Time:		Date:	
Patient's Full Name:			
Gender:	Date of birth:	Policy Number:	Effective date:
Telephone:	Cell Phone:	Fax:	

PHYSICIAN AND HOSPITAL INFORMATION

Primary Physician's Name:	
Telephone:	Fax:
Hospital / Clinic:	
Telephone:	Fax:
Treating Physician's Name:	
Telephone:	Fax:

PROCEDURE / SURGERY INFORMATION

Procedure / Surgery:	
Date of Service:	Date of Diagnosis:
Diagnosis (Please attach available reports):	
Hospitalized <input type="checkbox"/>	Outpatient <input type="checkbox"/>
Amount of days hospitalized if it applies:	
Pre-Notification issue date:	

Signature of Claimant or representative (if minor)

Day/Month/Year