INSURANCE CLAIM QUESTIONNAIRE

Please provide as much detail as possible. Signature is REQUIRED. This information will be submitted with your insurance claim(s).

Last Name:	First Name:
Date of Birth (MM/DD/YYYY):	
Date(s) of Doctor Visits or Accident (specify if visit or accident): 1. 2.. 3. . 4.	
Please list the reason for each doctor's visit, including details about your symptoms and diagnosis by doctor and/or, if applicable, description of accident (include location of accident): 1. 2. 3. 4.	
Date(s) first symptoms was notice by patient:	

HISTORY OF TREATMENTS (LIST DOCTORS YOU'VE SEEN FOR THE PAST 3 YEARS) – if applicable

Doctor's Name	Address/Phone	Date of Visit	Reason of Visit

Was this a sports related injury? ___ YES ___ NO
If yes, was this for ___ Collegiate Sports ___ Recreational Sports ___ Professional/Club ___ Other (specify):______________________

I confirm the information above is accurate to the best of my ability.

Patient Signature (REQUIRED):

1. PLEASE ATTACH ALL ORIGINAL RECEIPTS & MEDICAL BILLS.
2. EMAIL THIS COMPLETED QUESTIONNAIRE & COPIES OF RECEIPTS & MEDICAL BILLS TO: claims@myamericanyear.org or send copy via WeChat (ID: MyAmericanYear)
3. MAIL SIGNED QUESTIONNAIRE, ORIGINAL RECEIPTS, & ANY MEDICAL BILLS TO:

ERDT/enVision
Attn: Claims
7733 W 79th Street
Playa Del Rey, CA 90292