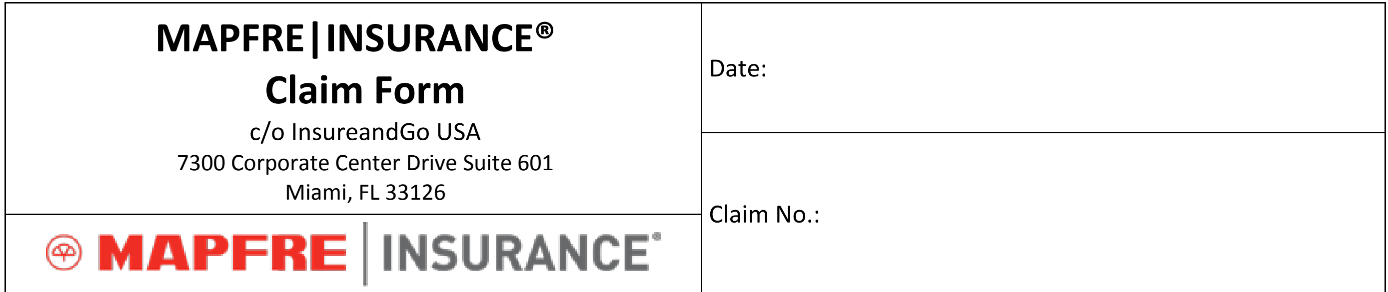


MAPFRE|INSURANCE® Claim Form c/o InsureandGo USA 7300 Corporate Center Drive Suite 601 Miami, FL 33126	Date:
MAPFRE | INSURANCE®	Claim No.:

To be Completed by Insured			
Name of Insured			
Insurance Purchase Date		Policy #	

To be Completed by Examining Physician					
Patient Information					
Patient's Name		Date of Birth			
Street Address					
City		State		Zip	
Telephone #		Fax #			
Physician Information					
Name		Telephone #			
Are you the patient's primary care physician? If **NO**, then please provide the primary care physician's name and telephone #.				☐ YES	☐ NO
Primary Care Physician's Name		Primary Care Physician's Telephone #			
Was the patient referred to you by the primary care Physician?				☐ YES	☐ NO

Patient's Diagnosis			
Did you Perform an Actual Examination?		☐ YES	☐ NO
Date of Examination			
Please indicate the primary diagnosis for which you examined the patient			
ICD-9 Code		Date Symptoms First Appeared or Accident Occurred	

Is the Illness/Injury attributable to the use of drugs or alcohol?	☐ **YES**	☐ **NO**

Has the patient been referred to or seen a doctor or needed inpatient treatment for this or other related condition within 6 months prior to the date of travel? If so, please explain.

Please list the dates of the patient's office visits in the 120 days before the insurance purchase date. List the dates where you treated the patient for the above stated condition. (Please continue on a separate sheet of paper if necessary)	1.	4.
	2.	5.
	3.	6.

Did you advise the trip be cancelled or interrupted due to the patient's medical condition?	☐ **YES**	☐ **NO**

Please explain why you made this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness

If the patient is the insured, on what date did he/she become medically unable to travel?	

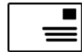
By my signature below, I hereby certify that the above is true and correct:

Physician Signature: ______________________________ Date: ______________

Return the complete form via email, fax, or mail to:

E-mail: mapfretravelclaims@insureandgousa.com

Fax: (877)570-9801



Mail: MAPFRE|INSURANCE® c/o InsureandGo USA
7300 Corporate Center Dr. Suite 601
Miami, FL 33126

For any questions please contact the below phone number.
Monday – Friday 9:00 AM to 5:00 PM EST

Phone: (888)838-0921

Insurance underwritten by American Commerce Insurance Company Plan administered by Insure & Go Insurance Services USA, Corp