Attending Physician's Statement

Arch | Insurance

Section 1: To be completed by claimant/insured

About the Claimant

Name of Claimant/Insured		Claim Number
Address (street, city, state, zip)		
Date of Birth	Trip Departure Date	Policy Date
Email Address		

About the Patient - Complete only if different from Insured

Name of Patient	Date of Birth
Was patient traveling with insured? Yes ☐ No ☐	Relationship of Patient to Insured

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

Patient's or Authorized Representative's Signature	If Authorized Representative, Relationship to Patient or Legal Designation	Date

Section 2: To be completed by physician

About the Diagnosis and Treatment

Diagnosis / ICD Code (primary diagnosis)		
Diagnosis / ICD Code (secondary diagnosis)		
What are the patient's symptoms?	Date symptoms first appeared?	
Date patient first consulted you for this condition?	Date of positive covid test, if applicable?	
Has the patient ever had this condition before? Yes ☐ No ☐	If yes, prior dates of treatment?	
Is this condition an exacerbation or a complication of an existing condition? Yes ☐ No ☐	If yes, when did the condition worsen?	
If the patient was referred **from or to** another physician, name and phone number of that physician?		
Dates of medical visits as they relate to the condition causing the trip cancellation/interruption. Date(s) of visit?	Was the patient seen for a physical exam? Yes ☐ No ☐	
Is the patient hospitalized or have they been in the past 12 months for this condition or related conditions? Yes ☐ No ☐		
If yes, Name & Location of Hospital?		
Dates of Hospitalization?		

Section 2, continued: To be completed by physician

About the Medical Condition as it relates to Travel

On what date was the Patient disabled and unable to travel?
Explain in detail reasons for restrictions that would prevent your patient's travel on date of departure.
How long will the patient be unable to travel?
If the patient was non-traveler, did you advise the Traveler to cancel or interrupt the trip due to the **non-traveler's** medical condition? Yes ☐ No ☐

If yes, please explain: Date you advised Traveler to cancel trip:	If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip?

Physician Information and Signature

Please note: All of the above requested information is necessary for the processing of the Claimant's claim. Any omitted items will delay processing.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

If this form is completed by a Nurse Practitioner, kindly include a Supervising Physician's signature where required by state regulations.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Physician's Signature	Date
Physician's Name	
License Number	Specialty
Phone Number	Fax Number
Affiliated Medical Facility Information, if applicable Facility Name & Location	

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Phone No: 1-877-722-1959
Fax: 1-443-279-2901
Email: claims@archinsurancesolutions.com
File a claim online at
Claims.archinsurancesolutions.com

Arch RoamRight
Phone No: 1-855-762-6252
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Email: claims@roamright.com
File a claim online at
roamrightclaims.com

Arch Red Sky
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Email: redsky@archinsurance.com
File a claim online at
Trippreserverclaims.com

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