

BEITLER SERVICES, INC., LLOYD'S COVERHOLDER  
&  
LLL INSURANCE SERVICES OF CALIFORNIA  
LICENSE #OF37860

CLAIM REPORT FORM

SHORT TERM MEDICAL EXPENSE  
LIABILITY INSURANCE FOR EGG DONORS AND RECIPIENTS

BSI Claim Number (to be assigned): \_\_\_\_\_ Date: \_\_\_\_\_

1. Insured Name and Address: \_\_\_\_\_  
\_\_\_\_\_

2. Name and Telephone Number of IVF Center Contact: \_\_\_\_\_  
\_\_\_\_\_

3. Policy Number: \_\_\_\_\_

4. Policy Period: From: \_\_\_\_\_ To: \_\_\_\_\_

5. Name of Injured Donor or Recipient: \_\_\_\_\_

6. Address and Telephone Number of Injured Donor or Recipient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Injured Donor or Recipient S.S. Number: \_\_\_\_\_

8. Is Injured Donor or Recipient currently employed? \_\_\_\_\_ Yes \_\_\_\_\_ No.

Does the Donor or Recipient currently have medical insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No.

From Employment \_\_\_\_\_

From School \_\_\_\_\_

From Parents \_\_\_\_\_

From Spouse \_\_\_\_\_

(a) Name of Plan Carrier: \_\_\_\_\_

(b) Plan/Policy Number: \_\_\_\_\_

(c) Please attach a copy of both sides of Donor or Recipient medical insurance card.

**BEITLER SERVICES, INC., LLOYD'S COVERHOLDER  
&  
LLL INSURANCE SERVICES OF CALIFORNIA  
LICENSE #OF37860**

**CLAIM REPORT FORM**

**SHORT TERM MEDICAL EXPENSE LIABILITY INSURANCE FOR EGG DONORS AND RECIPIENTS**

9. Insured Assigned / Reported File #, Recipient Name or Donor Initials and Month Injured Donor or Recipient Participant Reported by Insured to Program: \_\_\_\_\_  
\_\_\_\_\_
10. Date of Occurrence which caused the injury or illness: \_\_\_\_\_
11. Date the Donor or Recipient Started Cycle Treatment: \_\_\_\_\_
12. Please describe what occurred: \_\_\_\_\_  
\_\_\_\_\_
13. Name and Address of Hospital: \_\_\_\_\_
14. Name and Telephone Number of Physician: \_\_\_\_\_
15. Estimated Amount of Incurred Medical Expenses: \$ \_\_\_\_\_

**IN ADDITION TO THE ABOVE REQUIRED INFORMATION, UNDERWRITING AGENT REQUIRES:**

- If Donor or Recipient has other insurance coverage, copy of Insurer Explanation of Benefits 'EOB'.
- Hospital UB 92 Forms and Billing Statements.
- Physician, Labs, etc. HCFA Forms and Billing Statements.
- Injured Donor or Recipient IVF Treatment and / or Physician Medical Notes.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name

**PLEASE FAX COMPLETED CLAIM FORM AND ALL REQUIRED INFORMATION TO BEITLER SERVICES, INC.**