Guaranty of Payment #:_____

PROVIDER/PARTNER

Name:	Officer Name:
Email address :	Division:

PATIENT INFORMATION

Patient Name:	Date of Birth:
Policy No:	Expiry date:
Policy Holder:	
Product:	
Limitation:	
Excess:	

MEDICAL/ASSISTANCE INFORMATION

Physician Name:	Benefits:
Physician Specialty:	Motive:
Estimation cost :	
Service date:	Request date:

☐ **APPROVED** ☐ **PENDING** ☐ **REJECTED**

REMARKS

DISCLAIMER

1- ISA Assistance will only approve charges directly and strictly related to the case registered above. The final bill shall remain subject to billing rules, and to our audit department approval.
2- ISA Assistance hereby clearly reserves the right to decline any claim settlement due to misuse, abuse or tentative of fraud related either to the entry of the aforementioned information or to its trueness.
3- This form is subject to terms, conditions and procedures of the contract signed with ISA Assistance.