Azimuth Risk Solutions

Claim Form Questionnaire

Part 1 - Please complete all sections below

This claim is related to (Please check one):
☑ **Illness** ☐ **Condition** ☐ **Injury** ☐ **Dental** ☐ **Other**

Claimant/Insureds Name:
Magdaline Amalie James Devaraj

Date of Birth (MM/DD/YY):	**Gender:**	**Home/Cell Phone:**
12/08/1993	○ **Male** ◉ **Female**	6077610926

Mailing Address (Reimbursement checks will be mailed to this address):
591 Harley Dr, Apt 1

City, State:	**Postal Code:**	**Country:**
Columbus, Ohio	43202	USA

Email:
magdalinejames@gmail.com

How would like your claim(s) correspondence to be sent (Please check one):
☑ **Email** ☐ **Mailing Address**

Destination Country(ies):
USA

Citizenship of Claimant:	**Home Country of Claimant:**
Indian	India

Full-Time Student: ☐ **Yes** ☑ **No** **If yes, please provide the name and address of the school:**

Do you have additional Insurance? ○ **Yes** ◉ **No** **If yes, please complete the questions below.**

Name of Primary Insured of other insurance company:	**Date of Birth (M/D/Y):**

Policy #, Group # and name of other insurance policy:

Part 2 - Please complete all applicable questions below, although more information may be requested. (If you need additional space, please attach a separate sheet)

1. **What medical Illness, Condition or Injury are you being treated for? Please describe all symptoms.**

Vaginal Pain - Urinary Track Infection

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2. If Injury related, please describe how the injury occurred? (Specify what activity or sport as well as where you were located at the time of injury)

Home don't know how

3. When did the first symptom of this Illness, Condition or Injury begin (M/D/Y)?

3/15/2023

4. Have you ever been treated for this Illness, Condition or Injury before? ○ **Yes** ◉ **No**

If yes, please list the treatment dates (M/D/Y) and complete question #5.

5. List the names and addresses of all the providers you have seen for this Illness, Condition or Injury:

Scioto Urgent Care, 4760 Sawmill Rd, Columbus, OH 43235
Walmart Pharmacy, 2700 Bethel Rd, Columbus, OH 43220

6. Did your Injury involve a motor vehicle accident? ☐ **Yes** ☒ **No**

If yes, please provide the names of all parties involved, insurance carriers, policy numbers and the date of the accident (M/D/Y):

7. Was a police report filed? ☐ **Yes** ☒ **No**

If yes, please submit a copy of the police/accident report with this claim form.

8. Is this Illness, Condition or Injury related to a work accident? ☐ **Yes** ☒ **No**

If yes,please provide the workers compensation insurance information Below:

Part 3 - Authorization for Release of Medical Information

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Azimuth Risk Solutions, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Signature of Patient/Guardian:_____ **Date:** 3/17/2023 **(M/D/Y)**

Printed Name of Patient/Guardian: Magdaline Amalie James Devaraj **Date:** 3/17/2023 **(M/D/Y)**

Please mail, fax, or email completed form and supporting documents to:
Azimuth Risk Solutions
PO Box 627
Indianapolis, IN 46206
Email: service@azimuthrisk.com
Fax: +1 (317) 423-9620 | +1 (888) 201-8851 (outside of the US)