THIRD-PARTY DISCLOSURE & PAYMENT AUTHORISATION FORM

The purpose of this form is to authorise insurance companies to provide information and make payment of invoices regarding medical treatment.

Please complete and send us this form using one of the contact options at the bottom of the page.

Medical provider's name: _____

Insurance company's name: _____

Insured's name: _____

Policy/claim number: _____

I hereby authorise my insurance company to accept and pay the above-mentioned claim to the medical provider or to its business associate, OVAG International AG, Zurichstrasse 5, 6004 Lucerne, Switzerland.

Furthermore, I authorise my insurance to disclose my protected information to the above-mentioned provider and its business associate.

Should my insurance company involve another entity to process this claim in any way, this authorisation is to be extended accordingly. The cooperation between all involved parties, the prompt processing and payment of my outstanding balance is expressly requested.

_____ _____

Your Signature (or Signature of Personal Representative) **Date**

_____

Signatory's name in capital letters

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