VPI PET INSURANCE CLAIM FORM

VPI PET insurance

NO COVER SHEET NECESSARY. Fax to: 714-989-5600 No.of pages: _____

Take this form to your veterinarian to complete Section 2. Veterinarian's signature not required.

1 POLICYHOLDER INFORMATION

POLICY NO:_____

PET NAME:_____

BREED: _____

AGE: _____

NAME:_____

ADDRESS: _____

CITY:_____

STATE:_____ ZIP:_____

PHONE (H):_____

PHONE (B):_____

EMAIL:_____

2 Fill in below. ONE CLAIM FORM PER PET.

You must submit itemized receipts. You must provide us with veterinary medical records when we request them. Claims that are NOT COMPLETE or MISSING itemized, legible receipts or invoices may be delayed.

WELLCARE TREATMENTS	TREATMENT DATE	HOSPITAL/ CLINIC
☐ Annual Exam		
☐ Annual Lab Tests		
☐ Vaccinations		
☐ Dental		
☐ Spay/Neuter		
☐ Heartworm/Flea Medication		

DIAGNOSIS(ES) Please provide a diagnosis, or a tentative diagnosis, not a description of services performed.	TREATMENT DATE	HOSPITAL/ CLINIC

3 TOTAL AMOUNT SUBMITTED

$

You must submit receipts for all veterinary service charges. All submitted fees may not be eligible for coverage. Fees that exceed benefit schedule limits are your responsibility.

By signing this Claim Form, I confirm that to the best of my knowledge the information I have provided is true and correct. I authorize the release of my pet's medical records to Veterinary Pet Insurance Company/DVM Insurance Agency.

4 POLICYHOLDER SIGNATURE and DATE

X

5

FAX: *(Preferred Method)* **714-989-5600**

OR

MAIL:
VPI Claims Department
PO Box 2344, Brea CA 92822

PLEASE DO NOT USE STAPLES, PAPER CLIPS OR TAPE to attach receipts or invoices to your claim form.

To download claim forms: **petinsurance.com/forms**
QUESTIONS? Customer Care Dept: 800-540-2016

VPI DOCUMENT CENTER USE ONLY

CLAIMS NOTES (VPI use only)

FAX ONLY THE FRONT OF THIS CLAIM FORM. NO COVER SHEET REQUIRED.

CLAIM FORM CHECKLIST ☑

- ❑ I entered in my policy number, pet information and my contact information.
- ❑ This claim form includes only one pet.
- ❑ My veterinarian helped me complete Section 2 with the diagnosis(es), treatment date and the name of the hospital/clinic.
- ❑ I included all of my itemized and legible receipts/invoices.
- ❑ My pet's name and policy number are clearly identified on each receipt/invoice.
- ❑ I added up all my eligible receipts and entered the Total Amount Submitted.
- ❑ I signed and dated this claim form. (My veterinarian is not required to sign this form.)
- ❑ I submitted this claim form and all supporting receipts/invoices to the VPI Claims Department. I understand that claim forms that are incomplete or missing itemized and legible supporting receipts/invoices may be delayed.
- ❑ I kept a back-up copy of all documentation submitted for my records.
- ❑ If medical records are requested to process this claim, I understand that it is my responsibility to provide them to VPI.

Two ways to submit your claim:

Fax 714-989-5600

– OR –

VPI Claims Department, PO Box 2344, Brea, CA 92822

If FAXING your claim, DO NOT MAIL IT IN. Duplicate claims submission may delay processing.

Applicable in Ohio: any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.