F YOU ARE RETURNING TO YOUR HOME COUNTRY WITHIN 30 DAYS OF SENDING THIS CLAIM FORM TO GMMI, PLEASE CONTACT YOUR AGENT/INSURANCE CARRIER IN YOUR HOME COUNTRY TO CLAIM YOUR REIMBURSEMENT.

GLOBAL MEDICAL MANAGEMENT (GMMI, INC.) - CLAIM FOR REIMBURSEMENT

gmmi Global Medical Management

POLICY ID NUMBER		
INSURED INFO	Name	What type of claim is this? Medical ❑ Dental ❑ Miscellaneous, Travel Expenses etc. ❑
	Date of Birth	
	Postal address	Phone
	E-mail address	
PAYMENT	Recipient of compensation (if other than above)	
	Address (if other than above)	
INCIDENT /ACCIDENT	❑ accident ❑ employment accident ❑ motor vehicle accident	
	Date of accident	
	Date first saw physician	
	Is there other insurance involved?	
	Was there a police report filed? If yes, provide copy of police report.	
INCIDENT /ILLNESS	❑ Illness	
	Date of the first signs of illness	
	Date first saw physician	
	Have you had any previOus treatment for this condition? When?	
	If this is a DENTAL claim, explain nature of dental problem. Was there acute toothache involved?	
INCIDENT DESCRIPTION	Describe your illness or injury. If injury, how/when/where did it happen?	
TRAVEL DATES	Home Country Departure Date	Home Country Return Date

ENCLOSE ALL ORIGINAL RECEIPTS

EXPENSES

NAME OF DOCTOR/PHARMACY ETC.	Date of service	Amount
DENTAL EXPENSES		TOTAL $US
TOTAL CHARGES FOR REIMBURSEMENT		

SIGNATURE OF THE INJURED	**I hereby certify that the above statements are true and correct to the best of my knowledge. I authorize the insurance company, Global Medical Management, Inc. and/or any other authorized party to obtain, or release any information needed for the payment of my claim.**	
	Place and date	Signature

Please submit your claim form with ORIGINAL receipts of all expenses to:

Global Medical Management (GMMI, Inc.)
880 SW 145 Avenue, Suite 400
Pembroke Pines, FL 33027

gmmi's comments: