# TRIP CANCELLATION/TRIP INTERRUPTION ATTENDING PHYSICIAN STATEMENT

**THIS FORM IS REQUIRED IF THE CLAIM IS THE RESULT OF SICKNESS OR INJURY TO THE CARDHOLDER, A FAMILY MEMBER, A TRAVELING COMPANION, OR A TRAVELING COMPANION'S FAMILY MEMBER**


**Please Direct All Responses and Inquiries To:**
P.O. Box: 72034
RICHMOND, VA 23255
TELEPHONE: 1-800-356-8955
OR CALL COLLECT: 1-804-673-1691
eclaimsline@eclaimsline.com


## SECTION 1 – GENERAL INFORMATION – TO BE FILLED OUT BY CARDHOLDER (PLEASE TYPE OR PRINT)

| | | |
|---|---|---|
| First Name: | Primary Telephone: | |
| Last Name: | Alternative Telephone: | |
| Middle Name: | Email Address: | |
| Address: | Last 4 digits of Card #: | |
| | Date trip was booked: | |
| | Patient Name: | Relationship to Cardholder: |

## SECTION 2 – CLAIM INFORMATION – TO BE FILLED OUT BY ATTENDING PHYSICIAN

Date of accident, injury, or illness (MM/DD/YY):

Date of first treatment or onset (MM/DD/YY):

Please describe the nature of the patient's injuries or illness:

Was this a referral from another doctor? ☐ Yes ☐ No

If yes, date of referral (MM/DD/YY):

Was the patient hospitalized? ☐ Yes ☐ No

If yes, please list the names and locations of all hospitals and all admission/discharge dates:

| Hospital Name | Location | Adm. Date | Dis. Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Was the patient recommended by you to curtail their trip/travel due to this condition? ☐ Yes ☐ No

If yes, travel restriction dates advised (MM/DD/YY): ______________________________ to ______________________________

Did this travel restriction affect any other family members or travel companions? ☐ Yes ☐ No

If yes, why did family member/travel companion need to curtail their travel?

Did the patient have any condition (including pregnancy) prior to trip booking that contributed to their present condition? ☐ Yes ☐ No

If yes, please describe:

At what date did patient originally begin treatment with this previous condition (MM/DD/YY): ___________________________

Was the patient's previous condition stable at least 60 days prior to booking the trip? ☐ Yes ☐ No

Please describe:

For pregnancy, provide EDC (MM/DD/YY): ________________________________ ☐ Not Applicable

## SECTION 3 – ATTENDING PHYSICIAN INFORMATION – TO BE FILLED OUT BY ATTENDING PHYSICIAN

Name of Attending Physician:

Phone Number:

Address:

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete, or misleading information may be subject to prosecution for insurance fraud.

**SIGNED (Attending Physician):** **Date (MM/DD/YY):**