MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 14327
Reading, PA 19612
Telephone: 855.521.9345 Fax: 610.374.6986
Portal: https://medmutualprotect.loomislive.com

Travel and Lodging Claim Form

Instructions to file a claim:

1. Complete the travel and lodging claim form and mail, fax, or email per the above.
2. Include the itemized billing or UB form from the provider where service was rendered. Bill must include name and address of provider, date of service, and service rendered (CPT codes).
3. If flying, provide copy of plane ticket.
4. Lodging benefit: provide lodging receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.

Insured's Name *(Last, First, Middle)*	Policy/Certificate #	Social Security No.	Date of Birth	Sex *(M/F)*
Address *(Street, City, State, Zip)*			Phone Number *(With Area Code)*	
Patient's Name *(Last, First, Middle)*		Date of Birth	Relationship to Insured	

Travel: Date of Service(s)	Name & Address of Provider	Type of Travel ☐ Auto ☐ Plane
Service Traveled for:		

Lodging: Date of Service(s)	Name & Address of Provider	Name of Adult Companion/Family Member
Service Traveled for:		

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE INSURED'S SIGNATURE

DATE CLAIMANT'S SIGNATURE