

Policy Number: _____ Name: _____
 Address: _____
 City: _____ State: _____ Zip Code _____

Section 1: To be completed by the Policyholder

Pet's Name:	Date of Birth:
BEST phone number:	E-mail:

By my signature below, I authorize PurinaCare to request any medical records necessary to process this claim.
 POLICYHOLDER SIGNATURE: _____

Section 2: To be completed by Veterinarian providing care

If this claim includes **PREVENTIVE CARE SERVICES**, check this box

If this claim includes **MEDICAL or ACCIDENT SERVICES** complete the table section below

Diagnosis	Date	Check One	
		Initial Visit	Recheck
1)			
2)			
3)			
4)			
5)			

If you are unable to provide a diagnosis or tentative diagnosis, please list the major presenting symptoms in the space below, or please attach a printed copy of the medical history for the problem being presented.

- 1)
- 2)
- 3)

Hospital
Stamp
Here

CLAIMS SUBMISSION CHECKLIST: To facilitate a short claim turnaround time, please make sure you have done the following:

- Policyholder has filled out and signed Section 1
- The veterinarian or hospital representative has filled out and stamped Section 2
- Mail or Fax all original receipt(s) for all visits noted on the claim form to

Mail: P.O. Box 599500, San Antonio, Texas 78259
 Fax: 314-982-3312