RoamRight®
VENTURE FARTHER. TRAVEL SMARTER.

Attending Physician's Statement

Arch Insurance Company®

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-855-762-6252 | **Fax:** 443-279-2901
Email: claims@roamright.com

To be completed by Physician Rendering Treatment

Name of Claimant / Insured	Name of Patient	
Address		
Male ☐ Female ☐	Date of Birth	Trip Departure Date
What is the exact date that the symptoms first appeared?	Diagnosis/ICD-9 Code	
List all dates of treatment		
Did you advise patient to cancel or interrupt the trip due to the patient's medical condition? Yes ☐ No ☐		
If Yes, Please explain.		
Has patient ever had this condition before? Yes ☐ No ☐ If so, when?		
Has the patient consulted you for this condition before? Yes ☐ No ☐	List all dates of prior treatment	
Has the patient been treated by another physician for this condition before? Yes ☐ No ☐ If so, when was the patient treated?		
Please provide the name of the treating Physician	Phone No. ( )	
Is this condition an exacerbation or a complication of an existing condition? Yes ☐ No ☐		
If so, what was that condition?	When was the patient treated for that condition?	
Name of the physician who treated the underlying or original condition	Was the patient referred to you by another physician? Yes ☐ No ☐	
Name of Referring Physician	Phone No. ( )	
Was the Patient Hospitalized? Yes ☐ No ☐	Was this an emergency room admission? Yes ☐ No ☐	
Name of Hospital	Date Admitted	Date Discharged

Please note: All of the above requested information is necessary for the processing of the Claimant/Insured's claim. Any omitted items will delay processing. Please attach copies of the patient's office records for the 6 months prior to the trip departure date.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Physician _____ **Date** _____ **License No.** _____

Physician's Name _____ **Specialty** _____ **Phone No.** _____ **Fax No.** _____