



VPI PET INSURANCE CLAIM FORM

NO COVER SHEET NECESSARY. Fax to: 714-989-5600

No. of pages: _____

Take this form to your veterinarian to complete Section 2. Veterinarian's signature not required.

1 POLICYHOLDER INFORMATION

POLICY NO:

PET NAME:

BREED:

AGE:

NAME:

ADDRESS:

CITY:

STATE: **ZIP:**

PHONE (H):

PHONE (B):

EMAIL:

2 Fill in below. **ONE CLAIM FORM PER PET.** You must submit itemized receipts. You must provide us with veterinary medical records when we request them. Claims that are NOT COMPLETE or MISSING itemized, legible receipts or invoices may be delayed.

WELL CARE TREATMENTS	TREATMENT DATE	HOSPITAL/ CLINIC
<input type="checkbox"/> Annual Exam	/ /	West Oaks
<input type="checkbox"/> Annual Lab Tests	/ /	Animal Hospital, LLC
<input type="checkbox"/> Vaccinations	/ /	2820 W. Dorothy Jeanne S
<input type="checkbox"/> Dental	/ /	Fayetteville Ark 72704
<input type="checkbox"/> Spay/Neuter	/ /	(479) 442-4446
<input type="checkbox"/> Heartworm/Flea Medication	/ /	Dr. Nail / Dr. Cottle

DIAGNOSIS(ES) Please provide a diagnosis, or a tentative diagnosis, not a description of services performed.	TREATMENT DATE	HOSPITAL/ CLINIC
	/ /	
	/ /	
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	/ /	

3 TOTAL AMOUNT SUBMITTED

\$ _____

You must submit receipts for all veterinary service charges. All submitted fees may not be eligible for coverage. Fees that exceed benefit schedule limits are your responsibility.

By signing this Claim Form, I confirm that to the best of my knowledge the information I have provided is true and correct. I authorize the release of my pet's medical records to Veterinary Pet Insurance Company/DVM Insurance Agency.

4 POLICYHOLDER SIGNATURE and DATE

X _____ / /

5

FAX:

(Preferred Method)

714-989-5600

OR

MAIL:

VPI Claims Department
PO Box 2344, Brea CA 92822

PLEASE DO NOT USE STAPLES, PAPER CLIPS OR TAPE to attach receipts or invoices to your claim form.

To download claim forms: petinsurance.com/forms
QUESTIONS? Customer Care Dept: 800-540-2016

VPI DOCUMENT CENTER
USE ONLY

CLAIMS NOTES (VPI use only)