

HEALTH INSURANCE CLAIM FORM Claims must be submitted within 90 days of being incurred and original receipts/itemized bills must be attached.



1. TO BE COMPLETED BY EMPLO	OYEE / INSURED:	:				
Surname: First N		lame:	Date Of Birth: (d/m/yr):			
Address:)	
ID No.:	1.4	Telepho	one Nos.:	and treatment of	Talk to the second	
Patient's Name				Date Of Birth: (d/m/yr		
When did symptoms of the ailment first ap						
CAUSE OF CONDITION:			CO-ORDINATION	OF DENERITS.		
Is Patient's Condition Related To: (a) Emp	inlovment?	es 🗆 No		NOF BENEFITS: Any Other Plans, Which Provide Ber	-afte For This Injury or	
· · ·	ito Accident? Yes		Sickness? Yes		ielits pur rina mjar, c.	
, ,	her Accident? Yes			ne Of Insurance Company		
Details:				ured's Name		
If Yes, State Name of Employer's Insurer:			(c) Name	e of Group or Company Insured Une	der	
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and direct you to pay to ark nowledge and hereby authorize all doctors or other persons who treated me and I hospitals or other institutions to furnish full detailed information (including full opies of their records) regarding this claim Junderstand that I am financially responsible for charges not covered by the policy. Insured's Signature: ate: Date:						
Diagnosis	Date of Service d/m/yr		Description of Service		Charge \$	
					-	
1.71					+	
					+	
The second secon	 					
☐ SINGLE ☐ BI-FOCAL ☐ MULT	T POCAL EL LEN	TICLULAR FI CONTA	The state of the s	TOTA		
T SINGLE T DI-LOCAL TIMOPI.	I-FOCAL LENI	TCULAR LI CONTAC	CT LENSES SUNGLA	ASSES TOTA	ır 📗	
I HEREBY CERTIFY THAT THE ABOVE	E SERVICES AS IN	DICATED BY DATE I	HAVE BEEN COMPLETE	ĒD		
STAMP	SIGNA	TURE OF OPTICIAN/C	OPHTHALMOLOGIST/OI	PTOMETRIST DATE	ΓE	

TO DE COM	DI ETEN QV NACTAD	/ HEALTH PROVIDE	ER:		Patient's Name:	uter zifu i	THE RESERVED			
4. TO BE COMPLETED BY DOCTOR / HEALTH PROVIDER:				Date Of Birth: (d/m/yr)						
						1	P. d. C. i.e.			
Date of Visit Or Service	Diagnos	sis/ICD Code	Visit Fee	Type of Visit	Service Rendered (drugs, injections, tests, supplies)	Cost	Further Services Recommended			
71 Service										
						1				
l							39			
						 	THE RESERVE			
ate of first sym	ptoms:			На	is patient been previously treated for this	condition?	Yes No			
ate of first cons	sultation for this condition	: -		If	Yes, give date:					
as patient refer	rred? If "Yes" state name	of referring doctor:								
JRGICAL PR	ROCEDURES			Date of Surge	·					
escribe Proced	ure(s) Performed:					geon's Fee \$				
						sist's Fee \$	75 TO 10 TO			
IATERNITY	Date Pregnancy Co	mmenced/LMP:				Date of Delivery or Termination:				
	Type of Delivery:				Obstetric	Obstetrical Fee \$				
HEREBY CER	TIFY THAT THE ABOV	E SERVICES AS IND	ICATED B1	DATETIAV	E BEEN COMI EL LES					
STAI	MP	SIGNATURE OF DOCTOR/HEALTH PROVIDER DATE								
	APLETED BY DENTIS				Patient's Name:					
a) Is treatment a	a result of occupational ill a result of auto accident?	ness or injury?	Yes 🗌 1	No	sifyes)					
c) Other accide	nt?	Laborat See 6] Yes □ t		PRINCES (HEE CHARTING SVETEM	(SHOWN)				
636	COO				RVICES (USE CHARTING SYSTEM		Charge \$			
			Tooth # S	Surface(s)	Description of Servi	ce	Charge \$			
	3	(4/11/5/)	1111111			-				
83	CS.	- Conditions	Danif - L							
(63)										
			erbilin	_23						
258										
ET CO	(A)									
	الم الم		<u></u>			TOTAL				
- C	300°		CROWNS		INITIAL DENTUR	ES OR BRIDO	GES			
ORTHODONTI a) Date of first	IC TREATMENT appliance:	(a) Is thi	s an initial pla	cement? _	(a) Is this an initial	(a) Is this an initial placement?				
b) Data of last	appliance:	(b) Reas	on:		(b) Date of prior pla	(b) Date of prior placement:				
		(c) Date	of prior place	ment:	(c) Reason for repla	(c) Reason for replacement:				
(d) Monthly treatment fee: (d) Was root canal treatment performed?						(e) Date of extraction:				
(e) Total fee:						(f) Indicate teeth replaced by this appliance:				
HEREBY CEI	RTIFY THAT THE ABO	VE SERVICES AS IND	DICATED BY	DATE HAV	/E BEEN COMPLETED.					
STA	MP		SIGNATUI	RE OF DEN	TIST		DATE			