Sagicor

HEALTH INSURANCE CLAIM FORM

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

ATTIC

1. TO BE COMPLETED BY EMPLOYEE / INSURED:

Surname:_____ First Name:_____ Date Of Birth: (d/m/yr): _____

Address:_____

ID No.:_____ Telephone Nos.: _____ _____

Patient's Name_____ Relationship:_____ Date Of Birth: (d/m/yr) _____

When did symptoms of the ailment first appear? _____

Have you ever had this ailment before? If yes, state when and describe _____

CAUSE OF CONDITION:

Is Patient's condition related to: (a) Employment ? ☐ Yes ☐ No

(b) Accident ☐ Yes ☐ No

(c) Other Accident ☐ Yes ☐ No

Details:_____ If Yes, State Name of Employer's Insurer: _____

CO-ORDINATION OF BENEFITS:

Is Patient Covered By Any Other Plans, Which Provide Benefits For This Injury or Sickness? ☐Yes ☐ No

If "Yes", give (a) Name Of Insurance Company _____

(b) Insured's Name _____

(c) Name of Group or Company Insured Under _____

AUTHORIZATION:

I/we hereby certify that the foregoing answers are true and correct to the best of my/ our knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full detailed information (including full copies of their records) regarding this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or with intent to mislead, conceals information concerning any fact material thereto, commits a fraudulent act and is liable to prosecution.

Insured's Signature: _____

Spouse's Signature: _____

Date: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and direct you to pay to _____

_____

all benefits due to me or my covered dependant (s) as a result of this claim.

I understand that I am financially responsible for charges not covered by the policy.

Insured's Signature: _____

Date: _____

2. TO BE COMPLETED BY EMPLOYER / POLICYHOLDER:

Policy Holder:_____ Policy No: _____ Employee Certificate No.:_____ Effective Date:_____

Has employee made claim for Workmen's Compensation? ☐ Yes ☐ No Is he/she entitled to such benefits? ☐ Yes ☐ No

Company's Stamp:_____ Administrator's Signature:_____ Date: _____

3. TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:

Patient's Name: _____

Date Of Birth: (d/m/yr) _____

Diagnosis	Date of Service d/m/yr	Description of Service	Charge $
☐ SINGLE ☐ BI-FOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES ☐ SUNGLASSES		TOTAL	

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED

STAMP

SIGNATURE OF OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST

DATE

4. TO BE COMPLETED BY DOCTOR / HEALTH PROVIDER:

Patient's Name: _____

Date Of Birth: (d/m/yr) _____

Date of Visit Or Service	Diagnosis/ICD Code	Visit Fee	Type of Visit	Service Rendered (drugs, injections, tests, supplies)	Cost	Further Services Recommended

Date Of first Symptom _____ Has patient been previously treated for this condition? ☐ Yes ☐ No

Date of first consultation for this condition:_____ If Yes, give date: _____

Was patient referred? If "Yes" state name of referring doctor: _____

SURGICAL PROCEDURES Date of Surgery: Surgeon's Fee $

Describe Procedure(s) Performed: Asst. Surgeon's Fee $

Anaesthesist's Fee $

MATERNITY Date Pregnancy Commenced/LMP: Date of Delivery or Termination:

Type of Delivery: Obstetrical Fee $

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED

STAMP _____ SIGNATURE OF DOCTOR/HEALTH PROVIDER _____ DATE _____

5. TO BE COMPLETED BY DENTIST:

Patient's Name: _____

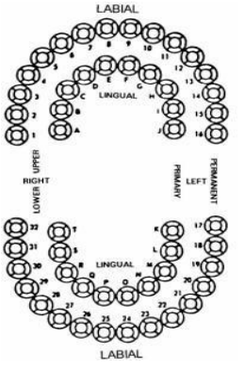
Date Of Birth: (d/m/yr) _____

DENTIST_____ TEL No: _____

(a) Is treatment a result of occupational illness or injury? ☐ Yes ☐ No (Details if yes) _____

(b) Is treatment a result of auto accident? ☐ Yes ☐ No _____

(c) Other accident? ☐ Yes ☐ No _____



LIST OF SERVICES (USE CHARTING SYSTEM SHOWN)

Date of Service (d/m/yr)	Tooth # or Letter	Surface(s)	Description of Service	Charge $
			TOTAL	

ORTHODONTIC TREATMENT

(a) Date of first appliance: _____

(b) Date of last appliance: _____

(c) Treatment period (no. of months):_____

(d) Monthly treatment fee: _____

(e) Total fee: _____

CROWNS

(a) Is this an initial placement?_____

(b) Reason:_____

(c) Date of prior placement:_____

(d) Was root canal treatment performed?_____

INITIAL DENTURES OR BRIDGES

(a) Is this an initial placement? _____

(b) Date of prior placement: _____

(c) Reason for replacement: _____

(d) Were teeth extracted for the appliance? _____

(e) Date of extraction: _____

(f) Indicate teeth replaced by this appliance: _____

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED.

STAMP _____ SIGNATURE OF DENTIST _____ DATE _____