HEALTH CLAIM FORM

REMEMBER TO ATTACH ORIGINAL RECEIPTS/ITEMIZED BILLS

Notification and proof of claim must be submitted within 90 days

1. TO BE COMPLETED BY EMPLOYER/INDIVIDUAL POLICYHOLDER

POLICY NO.	POLICYHOLDER	ADMINISTRATOR'S SIGNATURE
ID #		

2. TO BE COMPLETED BY EMPLOYEE/INSURED (PLEASE PRINT)

EMPLOYEE'S/INSURED'S NAME:	PATIENT'S NAME: DATE OF BIRTH:	NAME OF SPOUSE'S EMPLOYER
ADDRESS: TELEPHONE NO:	IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT ☐ YES ☐ NO b. AUTO ACCIDENT ☐ YES ☐ NO c. OTHER ACCIDENT ☐ YES ☐ NO IF "YES", GIVE DETAILS	

Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? ☐ Yes ☐ No

If "Yes", give (a) Name of Insurance Company ____________________

(b) Name of Group or Company insured under ____________________

I hereby authorize and direct you to pay to ____________________ all benefits accruing to me as a result of this claim to the extent of bills submitted.

AUTHORIZATION: I hereby authorize the doctor to release any information acquired in the course of my examination or treatment.

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 ____________________ Patient's Signature ____________________ Date ____________

3. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER

Patient's Name:	Name & Address of Doctor/Health Provider:
Diagnosis or Nature of Illness or Injury (ICD CODE) 1. 2. 3. 4.	GIVE NAME OF REFERRING PHYSICIAN

Is condition due to Pregnancy? ☐ Yes ☐ No If "Yes", give approximate date of last monthly period:

4. TO BE COMPLETED BY DOCTOR – MEDICAL/SURGICAL TREATMENT

Date of first symptoms:	Has patient been previously treated for this condition? ☐ Yes ☐ No
Date of first consultation for this condition:	If "Yes", give date:

A	B	C	D	E	
Date D M Y	Place of Service (Office/Home/Hosp.)	Procedures, Services or Supplies (Explain unusual circumstances)	Diagnosis 1, 2, 3, 4	Charges	$
I I					
I I					
I I					

FURTHER SERVICES RECOMMENDED	SURGICAL PROCEDURE	Charges	$
	Date of Operation		
	Type of Operation		
	Name of Surgeon		
	Name of Assistant Surgeon		
	Name of Anaesthetist		
	TOTAL		

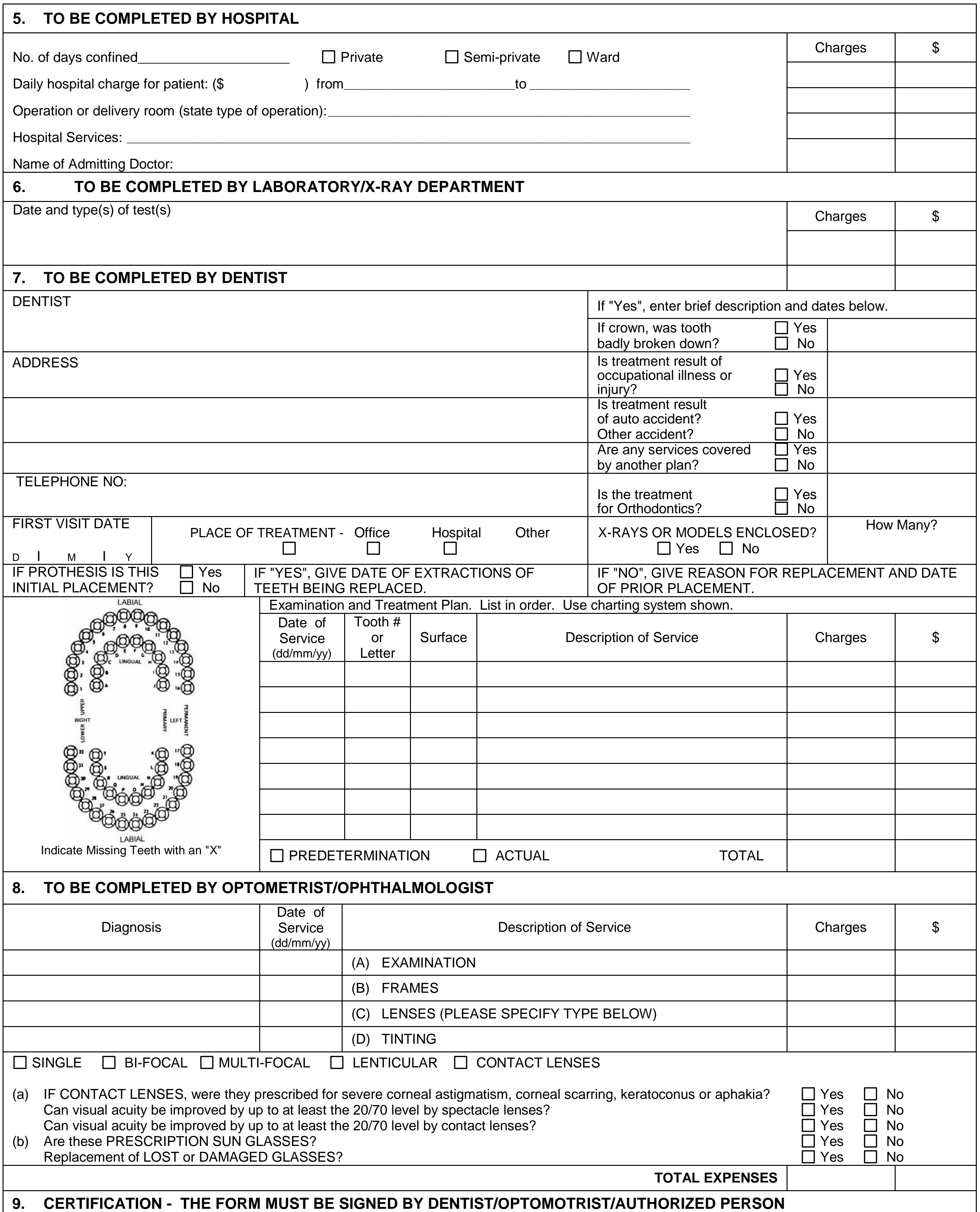
I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED.

____________________ ____________________ ____________________

Stamp Signature of Doctor Date

GI40007 – April 2014

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED UNLESS ASSIGNED.



5. TO BE COMPLETED BY HOSPITAL

	Charges	$
No. of days confined____________________ ☐ Private ☐ Semi-private ☐ Ward		
Daily hospital charge for patient: ($) from______________________to _____________________		
Operation or delivery room (state type of operation):____		
Hospital Services: ____		
Name of Admitting Doctor:		

6. TO BE COMPLETED BY LABORATORY/X-RAY DEPARTMENT

Date and type(s) of test(s)	Charges	$

7. TO BE COMPLETED BY DENTIST

	If "Yes", enter brief description and dates below.	
DENTIST	If crown, was tooth badly broken down? ☐ Yes ☐ No	
ADDRESS	Is treatment result of occupational illness or injury? ☐ Yes ☐ No	
	Is treatment result of auto accident? ☐ Yes Other accident? ☐ No	
	Are any services covered by another plan? ☐ Yes ☐ No	
TELEPHONE NO:	Is the treatment for Orthodontics? ☐ Yes ☐ No	

FIRST VISIT DATE D / M / Y	PLACE OF TREATMENT - Office ☐ Hospital ☐ Other ☐	X-RAYS OR MODELS ENCLOSED? ☐ Yes ☐ No	How Many?

IF PROTHESIS IS THIS INITIAL PLACEMENT? ☐ Yes ☐ No	IF "YES", GIVE DATE OF EXTRACTIONS OF TEETH BEING REPLACED.	IF "NO", GIVE REASON FOR REPLACEMENT AND DATE OF PRIOR PLACEMENT.

LABIAL / LINGUAL / UPPER / LOWER / RIGHT / LEFT / PRIMARY / PERMANENT / LINGUAL / LABIAL

Indicate Missing Teeth with an "X"

Examination and Treatment Plan. List in order. Use charting system shown.

Date of Service (dd/mm/yy)	Tooth # or Letter	Surface	Description of Service	Charges	$
☐ PREDETERMINATION		☐ ACTUAL	TOTAL		

8. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST

Diagnosis	Date of Service (dd/mm/yy)	Description of Service	Charges	$
		(A) EXAMINATION		
		(B) FRAMES		
		(C) LENSES (PLEASE SPECIFY TYPE BELOW)		
		(D) TINTING		

☐ SINGLE ☐ BI-FOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES

(a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia? ☐ Yes ☐ No
Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? ☐ Yes ☐ No
Can visual acuity be improved by up to at least the 20/70 level by contact lenses? ☐ Yes ☐ No
(b) Are these PRESCRIPTION SUN GLASSES? ☐ Yes ☐ No
Replacement of LOST or DAMAGED GLASSES? ☐ Yes ☐ No

TOTAL EXPENSES		

9. CERTIFICATION - THE FORM MUST BE SIGNED BY DENTIST/OPTOMOTRIST/AUTHORIZED PERSON

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

Stamp ______________ Signature of Doctor ______________ Date ______________