Sagicor

# HEALTH INSURANCE CLAIM FORM

**NOTE: CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF BEING INCURRED TO BE ELIGIBLE FOR REIMBURSEMENT**

## PATIENT AND INSURED INFORMATION

1. Insured's Name (Last Name, First Name, Middle Initial)

2. Insured's Address

Telephone (include area code)

3. Insured's Date of Birth D M Y | Sex ☐ M ☐ F

4. Insured's Policy No. | Cert. No.

5. Employer's Name

6. Is there another Health Benefit Plan? Yes ☐ No ☐ If "Yes", complete items13-13d

7. Insured's or Authorized person's signature.
*I authorize payment of medical benefits to:*

Hospital

Doctor

Surgeon

Signed _____ Date _____

8. Patient's Name (Last Name, First Name, Middle Initial)

10. Patient's Address

Telephone (include area code)

13. Other Insured's Name (Last Name, First Name, Middle Initial)

a. Other Insured's Policy or Group Number

b. Other Insured's Date of Birth D M Y | Sex M ☐ F ☐

c. Employer's Name

d. Insurance Plan Name or Program Name

9. Patient's Date of Birth D M Y | Sex ☐ M ☐ F

11. Patient's Relationship to Insured
Self ☐ Spouse ☐ Child ☐

12. Patient's Status
Single ☐ Married ☐ Divorced Separated ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

14. Is Patient's condition related to

a. Employment? (Current or Previous)
Yes ☐ No ☐

b. Auto accident?
Yes ☐ No ☐

c. Other accident?
Yes ☐ No ☐

Kindly describe on a separate sheet

15. I hereby certify that the foregoing answers are true and correct and I authorize all Doctors or other persons who treated me and all hospitals or other institutions to furnish full information ***(including full copies of their records)*** regarding this claim to Sagicor Life Inc. ***(Please indicate applicable company.)***

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.

Signed _____ (Insured) _____ (Spouse (if patient)) Date _____

Verified by Policy Holder/Plan Administrator Effective date of Insured's coverage _____ Effective date of Dependents' coverage _____

_____ (Signed) _____ (Company Stamp) _____ (Date)

## PHYSICIAN OR SUPPLIER INFORMATION

16. Date of Current Illness (First symptom) OR Injury (Accident) OR Pregnancy (LMP) D M Y

17. If Patient has had same or similar illness: Give first date D M Y

18. Dates Patient unable to work in current occupation
From D M Y To D M Y

19. Name of referring physician or other source

20. Hospitalization dates related to current services
From D M Y To D M Y

21. Diagnosis or nature of illness or injury
1. 2. 3. 4.

22. Outside Lab? Yes ☐ No ☐ | $ Charges

| 23. A Dates of Service D M Y | B Place of Service Off./Home/Hosp. | C Procedures, Services or Supplies (Explain Unusual Circumstances) | D Diagnosis 1,2,3,4 | E $ Charges | F Units or Days | G Further Services Recommended |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Additional information can be noted on separate sheet

24. Accept Assignment Yes ☐ No ☐

25. Total Charge $

26. Amount Paid $

27. Balance Due $

28. Signature of Physician or supplier including degrees or credentials

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

_____ _____ (Signed) _____ (Date)

29. Name and address of facility where services were rendered (if other than home or office)

30. Physician's, supplier's billing Name, Address and Telephone Number

**RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED UNLESS ASSIGNED**

## GUIDELINES

Our goal is to process your claim within the **10 day turnaround** time we have indicated to you. In order for us to fulfil this goal, you can help us by ensuring that the following guidelines are followed:

## THE CLAIM FORM

- Prepare **a separate claim form** for each family member.
- Complete **ALL** of the information requested with **EACH** claim submission.
- If you prefer that **benefits be paid to the provider of services, be sure to complete the authorization for assignment of benefits** section of the claim form.

## THE PROVIDER BILLING OR RECEIPT

Each bill receipt should carry:

- The name, address, person or organization providing the service.
- The name of the patient receiving the service.
- The date of each service **(a range of services cannot be accepted)**.
- The charge for each individual service.
- A description of each service.

On each bill, please delete any charges that were included on a previous claim. Personal itemizations, cash register receipts, credit card receipts and cancelled cheques are not acceptable. **PLEASE NOTE THAT ORIGINAL RECEIPTS CANNOT BE RETURNED UNLESS ACCOMPANIED BY CLEAR COPIES.**

**Accidental Injury** - Statements must contain details as to when, where and the manner in which the injury occurred as well as the name and address of the party at fault where applicable.

**Prescription only drugs** - Bills/receipts must include the prescription number, the name of the drug and the name of the physician prescribing the medication. **(Please note that the cost of each drug must be indicated and receipts must carry the name/stamp of the pharmacy).**

**Private Duty Nursing** - Bills/receipts must include the shift worked, the charge per hour, the number of hours worked, the nurse's professional status, the family relationship to the patient if any. A statement from the attending physician explaining the necessity of this service and the authorization of the service should accompany the claim.

**Prosthetic appliances and the rental or purchase of durable equipment** - A statement from the attending physician should accompany the claim. The statement should explain the medical necessity of the equipment and the physician's authorization for it.

**For patients covered by another insurance carrier** - If the patient is claiming benefits for any charges that are eligible for benefits under any other health insurance policy, the explanation of benefits worksheet furnished by the other company pertaining to these expenses must be included with the itemized bills. A CLEAR copy of the other carrier's explanation of benefits worksheet is acceptable in place of the original document.

Have you?

- ☒ Fully completed and signed the claim form.
- ☒ Attached all relating itemized bills/receipts.
- ☒ Kept copies of documentation for your records.
- ☒ Had your Plan administrator complete the employer's section.

Sagicor Life Inc
P.O. Box 104, Bridgetown, Barbados
Tel: (246) 467-7500 Fax: (246) 436-8829