



# HEALTH INSURANCE CLAIM FORM



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

1. Insured's Name (Last Name, First Name, Middle Initial)		8. Patient's Name (Last Name, First Name, Middle Initial)		9. Patient's Date of Birth D   M   Y		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
2. Insured's Address		10. Patient's Address		11. Patient's Relationship to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		12. Patient's Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>	
Telephone (include area code)		Telephone (include area code)		13. Other Insured's Name (Last Name, First Name, Middle Initial)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
3. Insured's Date of Birth D   M   Y		Sex M <input type="checkbox"/> F <input type="checkbox"/>		4. Insured's Policy No. Cert. No.		14. Is Patient's condition related to	
5. Employer's Name		a. Other Insured's Policy or Group Number		a. Employment? (Current or Previous) Yes <input type="checkbox"/> No <input type="checkbox"/>		b. Auto accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Is there another Health Benefit Plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", complete items 13-13d		b. Other Insured's Date of Birth D   M   Y		Sex M <input type="checkbox"/> F <input type="checkbox"/>		c. Other accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Insured's or Authorized person's signature. I authorize payment of medical benefits to:		c. Employer's Name		d. Insurance Plan Name or Program Name		Kindly describe on a separate sheet	
Hospital		d. Insurance Plan Name or Program Name		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 Sagikor 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.	
Doctor		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 Sagikor Life Inc. (Please indicate applicable company.)		Signed _____		Date _____	
Surgeon		Signed _____		Insured		Spouse (if patient)	
Signed _____		Date _____					

PATIENT AND INSURED INFORMATION

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

Signed _____		Company Stamp _____		Date _____	
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		22. Outside Lab? Yes <input type="checkbox"/> No <input type="checkbox"/> \$ Charges	
21. Diagnosis or nature of illness or injury 1. _____ 2. _____ 3. _____ 4. _____		23. A		23. B	
23. A		23. B		23. C	
23. B		23. C		23. D	
23. C		23. D		23. E	
23. D		23. E		23. F	
23. E		23. F		23. G	
23. F		23. G		23. H	
23. G		23. H		23. I	
23. H		23. I		23. J	
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23. L		23. M		23. N	
23. M		23. N		23. O	
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23. HT		23. HU		23. HV	
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## 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.