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 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: ______________________

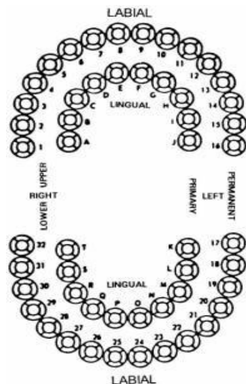
Date Of Birth: (d/m/yr) ______________________

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