



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) Auto 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

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 \$
<input type="checkbox"/> SINGLE <input type="checkbox"/> BI-FOCAL <input type="checkbox"/> MULTI-FOCAL <input type="checkbox"/> LENTICULAR <input type="checkbox"/> CONTACT LENSES <input type="checkbox"/> SUNGLASSES			TOTAL

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

STAMP

SIGNATURE OF OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST

DATE

Patient's Name: _____

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

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

Date of Surgery:

Surgeon's Fee	\$
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Asst. Surgeon's Fee \$

Anaesthetist's Fee \$

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

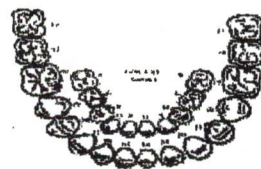
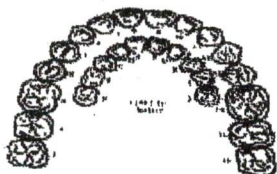
DATE _____

Patient's Name: _____

DENTIST _____ TEL No: _____

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

- (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

CROWNS

INITIAL DENTURES OR BRIDGES

- (a) Date of first appliance: _____ (a) Is this an initial placement? _____ (a) Is this an initial placement? _____
- (b) Date of last appliance: _____ (b) Reason: _____ (b) Date of prior placement: _____
- (c) Treatment period (no. of months): _____ (c) Date of prior placement: _____ (c) Reason for replacement: _____
- (d) Monthly treatment fee: _____ (d) Was root canal treatment performed? _____ (d) Were teeth extracted for the appliance? _____
- (e) Total fee: _____ (e) Date of extraction: _____ (e) Date of extraction: _____
- (f) Indicate teeth replaced by this appliance: _____ (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 _____