MED access

HEALTH INSURANCE CLAIM FORM

1 TO BE COMPLETED BY EMPLOYEE/INSURED

Surname: .... First Name: .... Date of Birth: *(dd/mm/yy)* ....

Patient's Name: .... Relationship: .... Date of Birth: *(dd/mm/yy)* ....

When did the 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: ....

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorise 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: *(dd/mm/yy)* ....

AUTHORISATION:

I/we hereby certify that the forgoing 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 detailed information *(including full copies of their records)* regarding this claim.

Insured's Signature: .... Spouse's Signature: .... Date: *(dd/mm/yy)* ....

2 TO BE COMPLETED BY HUMAN RESOURCES DEPT.

Policy Holder: .... Policy No.: .... Employee Certificate No.: .... Effective Date: *(dd/mm/yy)* ....

Has employee made claim for Workmen's Compensation? ◯ Yes ◯ No Is he/she entitled to such benefits? ◯ Yes ◯ No

Company Stamp: .... Administrator's Signature: .... Date: *(dd/mm/yy)* ....

3 TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:

Patient's Name: ....

Date of Birth: *(dd/mm/yy)* ....

Diagnosis	Date of Service *(dd/mm/yy)*	Description of Service	Charge $

◯ SINGLE ◯ BI-FOCAL ◯ LENTICULAR ◯ CONTACT LENSES

Total

I hereby certify that the above services as indicated by date have been completed

Official Stamp: .... Signature of Optician/Ophthalmologist/Optometrist: .... Date: *(dd/mm/yy)* ....

Claims must be submitted within 90 days of being incurred and original receipts/itemised bills must be attached.

4 TO BE COMPLETED BY PHYSICIAN/HEALTH PROVIDER:

Patient's Name: ....

Date of Birth: *(dd/mm/yy)* ....

Date of Visit or Service *(dd/mm/yy)*	Diagnosis/ICD Code	Visit Fee	Type of Visit	Service Rendered *(drugs injections tests supplies)*	Cost	Further Services Recommended

Date of first symptoms: *(dd/mm/yy)* .... Has patient been previously treated for this condition? ◯ Yes ◯ No

Date of the first consultation for this condition: *(dd/mm/yy)* .... If "Yes", give date: *(dd/mm/yy)* ....

Was patient referred? ◯ Yes ◯ No If "Yes", state name of referring doctor: ....

SURGICAL PROCEDURES: Date of Surgery: *(dd/mm/yy)* .... Surgeon's Fee: $ ....

Describe Procedure(s) Performed: .... Asst. Surgeon's Fee: $ ....

.... Anaesthesist's Fee: $ ....

....

....

MATERNITY: Date Pregnancy Commenced: *(dd/mm/yy)* .... Date of Delivery or Termination: *(dd/mm/yy)* ....

Type of Delivery: .... Obstetrical Fee: $ ....

I hereby certify that the above services as indicated by date have been completed

Official Stamp: .... Signature of Doctor/Health Provider: .... Date: *(dd/mm/yy)* ....

5 TO BE COMPLETED BY DENTIST:

Patient's Name: ....

Date of Birth: *(dd/mm/yy)* ....

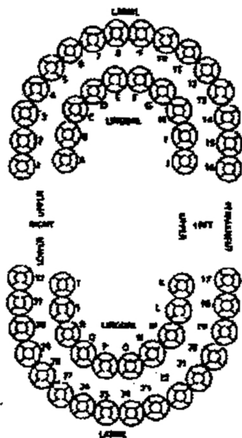
DENTIST: .... TEL No: ....

(a) Is treatment a result of occupational illness or injury? ◯ Yes ◯ No (If "Yes", details) ....

(b) Is treatment a result of auto accident? ◯ Yes ◯ No ....

(c) Other accident? ◯ Yes ◯ No ....

(d) Orthodontic Treatment? ◯ Yes ◯ No ....



LIST OF SERVICES *(USE CHARTING SYSTEM SHOWN)*

Date of Visit or Service *(dd/mm/yy)*	Tooth # or Letter	Surface(s)	Description of Service	Charge $

I hereby certify that the above services as indicated by date have been completed

Official Stamp: .... Signature of Dentist: .... Date: *(dd/mm/yy)* ....

Claims must be submitted within 90 days of being incurred and original receipts/itemised bills must be attached.