HEALTH INSURANCE CLAIM FORM

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. P.O. BOX

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS(First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. I.D. NUMBER OF REFFERRING PHYSCIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG.	J. COB.	K. RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

PIN # GRP #

CLAIMS MUST BE SUBMITTED WITHIN 180 DAYS OF THE DATE THE CHARGES WERE INCURRED.

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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CINICO

INSTRUCTIONS ON HOW TO CORRECTLY FILE YOUR CLAIM

The attached form is to be used to submit a claim for health services rendered under your Health Insurance Plan. To avoid delays or having your claim returned as incomplete kindly follow the following easy steps:

- ✓ Prepare a separate claim form for each family member
- ✓ Complete ALL of the information requested
- ✓ Provide an original itemized bill from each Provider of Service. Each itemized bill must contain:
  - Name of the patient receiving the service
  - Dates for each individual service
  - Time Units for anaesthesia
  - Charge for each individual service
  - Description of each service
  - Must be submitted on the Provider of Service Letterhead
  - CPT Procedure Coding (Healthcare Provider to provide)
  - ICD-9 Coding (Healthcare provider to provide)
  - Charges in Cayman islands Currency or USD currency only

Kindly do not include charges that have already been included on a previous claim, or personal itemizations, cash register receipts, credit card receipts and/or cancelled cheques as these are not acceptable. Official Receipts only are to be submitted attached to your claim.

The following information will be compulsorily required on your claim as follows:

Line 2 = Patient Name (the person who received the service)

Line 3 = Patient Date of Birth

Line 4 = Insured's Name

Line 5 = Patient's Address including PO Box Number

Line 6 = Patient's Relationship to Insured. Self/Spouse/Child or Other

Line 7 = Insured's Address including PO Box Number

Line 8 = Patient Status = Single or Married or Other

Employed Full Time Employed Part Time Part Time Student

Line 9 = Other Insured's Name (Last, First, Middle)

a) Other Insured's Policy or Group Number
b) Other Insured's Date of Birth
c) Employers Name or School Name

- (Line 9 is to ensure that your Spousal insurance coverage is known for co-ordination of benefit purposes) Line 9 (c) requires that for full time students the Education Facility's Name be filled in here. Line 9 (d) requests the name of the Insurance Plan or Program

Line 10 = Is patient's condition related to:

a) employment (current or previous) e.g. Hurt at work?
b) auto accident yes or no (Place = where did it happen)
c) other accident yes or no (How did you hurt yourself? E.g. Home, Garden,Beach etc.

Line 11 = Insured's Policy Group

a) Insured's date of birth
b) Employers Name or School Name
c) Insurance Plan Name or Programme Name
d) Is there another Health Benefit Plan? (List any other health insurance coverage that your name is listed on as a dependant or beneficiary)

Line 12 = MUST BE SIGNED and dated (FOR REIMBURSEMENT TO MEMBER) Paid Receipts
Line 13 = Insured's or Authorized person's signature= MUST BE SIGNED (FOR REIMBURSEMENT TO THE PROVIDER AND NOT THE MEMBER) Unpaid receipts

All other questions below the bolded line are pertaining to the medical component of your claim. These questions are best completed by your Provider of Service and you may wish to have them complete this section with you as special coding is required which may or may not be present on your itemized bill.

Lines 25,26,27 Not required
Lines 28,29 & 30 = Must match your total receipts Line 31 = Signed by the Provider or Service
Lines 32 & 33 = Providers Stamp

Following all of the above steps will result in a claim which can be submitted to the Claims Department for immediate submission provided all elements of information, inclusive of invoices and matching receipts are presented with the claim.

Only claims that are complete and are accompanied by the invoice and matching receipt will be accepted.

If you are unsure of any element of your claim, you may request to speak with a Claims Administrator BEFORE leaving your claim at Reception.

Although we are unable to complete the claim form on your behalf for legal purposes, we are at all times happy to assist you with additional questions you may have.