Tatil
... where people are people

HEALTH INSURANCE CLAIM FORM

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

ATTIC

1. TO BE COMPLETED BY EMPLOYEE / INSURED:

Surname: ..... **Name:** ..... **Date of Birth:** .....

Address: .....

ID No.: ..... **Telephone Nos.:** .....

Patient's Name: ..... **Relationship:** ..... **Date of Birth:** .....

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 oftheir 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 Insured's Signature, with intent to mislead, conceals information concerning any fact material thereto, commits a fraudulent act and is liable to prosecution.

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: .....

Insured's Signature: ..... Spouse's Signature: ..... Date: .....

2. TO BE COMPLETED BY EMPLOYER / POLICYHOLDER:

Policy Holder: ..... **Policy No.:** ..... **Employee Cert.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 (DD/MM/YY): .....

Diagnosis	Date of Service (DD/MM/YY)	Description of Service	Charge ($)

☐ **SINGLE** ☐ **BI-FOCAL** ☐ **MULTI-FOCAL** ☐ **LENTICULAR** ☐ **CONTACT LENSES** ☐ **SUNGLASSES** **TOTAL** 0.00

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 (DD/MM/YY): .....

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 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: .....

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: .....

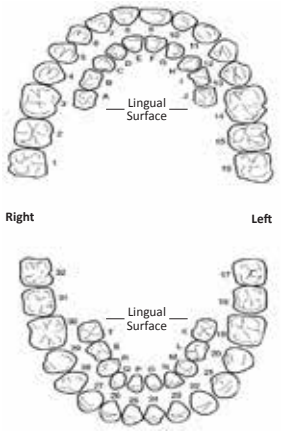
Date of Birth (DD/MM/YY): .....

Dentist: ..... Tel No.: .....

(a) Is treatment a result of occupational illness or injury? ☐ Yes ☐ No If **"Yes"**, give details: .....

(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 (DD/MM/YY)	Tooth # or Letter	Surface(s)	Description of Service	Charge ($)
			TOTAL	0.00

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: $0.00.....

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**