ATLANTIC MEDICAL

HealthInsurance

HEALTH
Claim Form

Claim No._____

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 180 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

PART 1 - To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured _____

Group Policy No._____ Certificate/Employee No. _____

Name of Employer_____ Transit No. _____

Full Name of Patient _____

Patient's Mailing Address_____ Tel. No. _____

Patient's Date of Birth (DD/MM/YY)_____ Patient's Gender ☐ Male ☐ Female

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If the Patient has any other Health Insurance coverage, provide name of policy holder and policy number _____

Was sickness/injury related to ☐ Patient's employment ☐ Traffic Accident ☐ Pregnancy ☐ Other (give details below)

_____

DECLARATION:

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions to furnish full information, including full copies of records, regarding this claim to Colonial Medical Insurance Company.

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS (SIGN ONLY IF REQUESTING DIRECT PAYMENT TO HOSPITAL OR DOCTOR):

I hereby authorise payment directly to the hospital, and physician where applicable, named on the attached claim form, other than Insurance Benefits under Policy....., otherwise payable to me but not to exceed the regular charges for the treatment and/or services supplied. I understand that I am financially responsible for the charges not covered by the Policy.

Patient's or Authorised Person's Signature _____ Date _____

PART 2 - To be completed by the ATTENDING PHYSICIAN

(A separate claim form or itemized account should be submitted by each attending physician.)

Date of illness (first symptom), injury (accident) or pregnancy (last monthly period) (DD/MM/YY) _____

Date patient first consulted you for this condition (DD/MM/YY) _____

Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Name of referring physician or other source _____

Hospitalisation dates related to current services (if applicable) Admitted (DD/MM/YY) _____ Discharged (DD/MM/YY) _____

Name and address of facility where services rendered (if other than home or office) _____

Was laboratory work performed outside your office? ☐ Yes ☐ No

Was the following operation(s) to correct a condition detrimental to the patient's health? ☐ Yes ☐ No

Diagnosis or Nature of Illness/Injury _____

_____

_____

_____

DATE OF SERVICE	PLACE OF SERVICE*	PROCEDURE CODE	FULL DESCRIPTION OF TREATMENT FOR EACH DATE GIVEN	DIAGNOSIS CODE	CHARGES	DAYS/UNITS	TYPE OF SERVICE*

*PLACE OF SERVICE
1 - IH = Inpatient Hospital
2 - OH = Outpatient Hospital
3 - O = Doctor's Office
4 - H = Patient's Home
5 - IL = Independent Laboratory

*TYPE OF SERVICE
1 = Medical Care
2 = Surgery
3 = Consultation
4 = Diagnostic Laboratory
5 = Anaesthesia (Duration Required)
6 = Assistance at Surgery
7 = Other Medical Service

Patient's Account Number	Total Charges	Amount Paid	Balance

DECLARATION OF PHYSICIAN OR SUPPLIER:

I certify that the statements on this form are true and complete to the best of my knowledge.

Full Name _____ Telephone _____

Mailing Address _____

Signature _____ Date _____

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