



HEALTH INSURANCE CLAIM FORM

1. Patient's Name (First, middle initial, last)		2. Patient's Birthdate DD/MM/YY		3. Insured's Name (First, middle initial, last)	
4. Patient's Full Address & Phone Number		5. Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Is Dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name and address of school	
		7. Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
8. Insured's Policy Number		10. Was condition related to A. Patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No B. An accident <input type="checkbox"/> Yes <input type="checkbox"/> No		11. If an accident, give date and brief details	
9. Does patient have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. AUTHORIZATION I certify that the information furnished by me in support of this claim is true and correct. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, pharmacist, educational institution or other person to release any information requested with respect to this claim. A photostatic copy or other reproduction of this release will be as the original.				DATE AND SIGNATURE OF INSURED / PATIENT	

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of illness (first symptom), injury or pregnancy (LMP)		15. Date first consulted you for this condition		16. Has patient ever had same or similar symptoms? <input type="checkbox"/> YES <input type="checkbox"/> NO	
17. Date patient able to return to work	18. Type of disability <input type="checkbox"/> Partial <input type="checkbox"/> Total	Disabled from: DD/MM/YY	Disabled to: DD/MM/YY	19. Hospitalized from: DD/MM/YY	Hospitalized to: DD/MM/YY
20. Name and address of referring physician			21. Name and address of facility where services rendered		
22. Please list any other insurance companies with which you have filed this claim.					
23. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to numbers 1,2,3, etc. or DX code					
1.					
2.					
3.					
4.					
24. Date of Service	Place of Service	Procedure Code	Description of Procedure, Service or Supply	Diagnosis Code	25. Charges
26. Signature of Physician or Supplier, Date (DD/MM/YY)				28. Total Charge	29. Paid