

Generali Worldwide Health Insurance Claim Form

For Medical, Dental and Vision Claims

Claim Number: _____ <small>(SSNor ID) _____ (ID)</small>		GROUP HEALTH PLAN _____ OTHER _____	1. INSURED'S ID NO. (FOR PROGRAM IN ITEM 1) _____ - _____ - _____																		
2. PATIENT'S NAME (Last Name, First Name, Middle Name)		3. PATIENT'S BIRTH DATE _____ SEX _____ M _____ F _____		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT'S RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)																	
CITY _____ STATE _____		8. PATIENT STATUS Single _____ Married _____ Other _____		CITY _____ STATE _____																	
ZIP CODE _____	TELEPHONE (include area code) _____	Employed _____ Full-time _____ Part-time _____ Student _____ Student _____		ZIP CODE _____ TELEPHONE (include area code) _____																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FECA NO.																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) _____ YES _____ NO		a. INSURED'S DATE OF BIRTH _____ SEX _____ M _____ F _____																	
b. OTHER INSURED'S DATE OF BIRTH _____ SEX _____ M _____ F _____		b. AUTO ACCIDENT? _____ PLACE (state) _____		b. EMPLOYER'S NAME OR SCHOOL NAME																	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? _____		c. INSURANCE PLAN NAME OR PROGRAM NAME Generali Worldwide																	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? _____ YES _____ NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? _____ YES _____ NO If Yes, return to and complete item 9 a-d																	
12. PATIENTS 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 ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES UNABLE TO WORK IN CURRENT OCCUPATION FROM _____ TO _____																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. ID NO. OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM _____ TO _____																	
19. RESERVED FOR LOCAL USE				20. OUTSIDE LABS? _____ \$CHARGES _____ (Indicate Currency) _____ YES _____ NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24B BY LINE) 1. _____ 2. _____ 3. _____ 4. _____				23. PRIOR AUTHORIZATION NUMBER																	
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE FROM _____ TO _____		TYPE OF SERVICE		PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MOD DX CODE Procedure		DAYS OR UNITS		EPST Family Plan		EMG		COB		\$ CHARGES							
25. FEDERAL TAX ID NUMBER _____ SSN _____ EIN _____		26. PATIENT'S ACCOUNT NO.		26. ACCEPT ASSIGNMENT? _____ YES _____ NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)				31. SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____													

