



GENERAL

PLEASE ATTACH ORIGINAL BILLS

MEDICAL INSURANCE CLAIM FORM

SECTION A. ENROLLEE AND PATIENT INFORMATION		
PATIENT'S IDENTIFICATION NUMBER:	PATIENT'S DATE OF BIRTH:	POLICY ID/ POLICYOWNER/ PLAN SPONSOR:
PATIENT'S NAME (Last, First, Middle):	PATIENT'S RELATION TO ENROLLEE: [] Self [] Spouse [] Child [] Other	ENROLLEE'S NAME (Last, First, Middle):
PATIENT'S MAILING ADDRESS (P O Box):	PATIENT'S STATUS: [] Single [] Married [] Other [] Employed [] Student [] Other	ENROLLEE'S MAILING ADDRESS (P O Box):
PATIENT'S STREET ADDRESS:	PATIENT'S CONDITION RELATED TO: [] Employment, date: _____ [] Auto accident, date: _____ [] Other emergency, date: _____	ENROLLEE'S STREET ADDRESS:
PATIENT'S PHONE & FAX NUMBERS:	[] Pregnancy, LMP: _____ [] Substance abuse, date: _____	ENROLLEE'S PHONE & FAX NUMBERS:
PATIENT'S OTHER HEALTH INSURANCE (if any):	[] Other, date: _____	ENROLLEE'S OTHER HEALTH INSURANCE (if any):

<p align="center">PATIENT'S AUTHORISATION</p> <p>I authorise Sagicor General Insurance (Cayman) Ltd. to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.</p> <p>Signature _____ Date _____</p>	<p align="center">PAYMENT ASSIGNMENT</p> <p>I authorise Sagicor General Insurance (Cayman) Ltd. to pay the proceeds claim to the undersigned Medical Services Provider.</p> <p>Signature _____ Date _____</p>
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SECTION B. MEDICAL PROVIDER INFORMATION						
DATE OF FIRST SYMPTOM OR LMP:	IF PATIENT HAD SUFFERED SAME OR SIMILAR ILLNESS BEFORE, GIVE DATE(S):		IF PATIENT WAS UNABLE TO WORK DUE TO THIS ILLNESS, GIVE DATE(S):			
NAME AND ADDRESS OF REFERRING OR PREVIOUS PHYSICIAN, OR OTHER SOURCE:			IF PATIENT WAS HOSPITALISED FOR THIS ILLNESS,			
DATE YOU FIRST TREATED PATIENT FOR THIS ILLNESS:	WAS OUTPATIENT DIAGNOSTIC SERVICES ORDERED, OR MEDICATION PRESCRIBED? [] Yes [] No		NATURE OF ACCIDENT, IF APPLICABLE:			
DIAGNOSIS, ILLNESS OR INJURY*			TREATMENT SERVICES*			
CODE	DESCRIPTION	DATE(S) From To		CODE	DESCRIPTION	CHARGE C\$

* If required, additional information may be detailed on the reverse side of this form.

PATIENT ACCOUNT NO:	ACCEPT ASSIGNMENT? [] Yes [] No	TOTAL CHARGE: C\$	PATIENT RESPONSIBILITY: C\$	BALANCE OUTSTANDING: C\$
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I certify that the information furnished above is true and correct to the best of my knowledge.

PROVIDER NAME:	PROVIDER TELEPHONE NUMBER:	PROVIDER REGISTRATION NUMBER:
PROVIDER ADDRESS:	PROVIDER'S SIGNATURE:	DATE:

