CG | INSURANCE

HEALTH CLAIM FORM

Claim No. _____

Premier Health

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_claims_BM@cgcoralisle.com or via Fax to 441 295 9036.

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

Full Name of Insured _____

Policy No. _____ Certificate No. _____

Name of Employer _____

Full Name of Patient _____

Patient's Mailing Address _____

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

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

If you have 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 Coralisle Medical Insurance Company Ltd.

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 form to be submitted by each physician)

Date of illness (first symptom), injury (accident) or pregnancy (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 (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

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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 _____

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda
PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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Rev. 01-21