Health Insurance Department

Personal Home Care Services - Claim Form

This Claim Form must be submitted to HID. **As per Legislation, reimbursement may take up to thirty (30) days from the submission date. Please Note: If the form is completed incorrectly or is incomplete, the claim will be denied.**

Policyholder's Name (First Name, Middle Initial and Last Name):	HID Policy ID:	Date of Birth (mm/dd/yyyy):
Provider to be Paid (Agency or Individual Caregiver Name):	Care Provider Name (If different from Provider to be Paid):	

CPT Codes:
Personal Caregiver: G0156 **Adult Day Care: S5101 (half day or 4 hours)**
Skilled Caregiver (Nurse Associate): S9122 **S5102 (full day)**
Registered Nurse: S9124

Place of Service:
☐ (12) Home
☐ (32) Nursing Home (for day care)
☐ (33) Rest Home (for day care)

Date (mm/dd/yyyy)	CPT Code	Start Time	End Time	Total Hours (Enter full hours)	Hourly Charge	Charges (Total Hours x Hourly Charge)

Policyholder or Responsible Person Signature: "I confirm receipt and authorize payment of medical benefits to the undersigned provider/caregiver for the service(s) described above."

Signed: Date (mm/dd/yyyy):

Care Provider's Signature: Date (mm/dd/yyyy):

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.hip.gov.bm **Email:** hip@gov.bm