HEALTH INSURANCE CLAIM FORM

APPROVED BY THE BERMUDA HEALTH COUNCIL (September 2013)

PLEASE PRINT OR TYPE IN UPPERCASE LETTERS

PATIENT AND INSURED INFORMATION

1. NAME OF INSURANCE COMPANY
ARGUS ☐ BF&M ☐ COLONIAL ☐ GEHI ☐ HID ☐ OTHER:____________________ ☐

1a. INSURED'S CERTIFICATE NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YYYY — SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

PARISH

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

PARISH

POSTAL CODE | TELEPHONE (Include Area Code) ( )

POSTAL CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
b. AUTO ACCIDENT? YES ☐ NO ☐
c. OTHER ACCIDENT? YES ☐ NO ☐

11. INSURED'S POLICY GROUP NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. INSURED'S DATE OF BIRTH MM DD YYYY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YYYY — SEX M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

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 ______________________________

PHYSICIAN OR PROVIDER INFORMATION

14. DATE OF CURRENT: MM DD YYYY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YYYY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YYYY TO MM DD YYYY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YYYY TO MM DD YYYY

19. ADDRESS

20. HOSPITAL LAB? YES ☐ NO ☐ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Related Items 1, 2, 3 or 4 to Item 23E by Line)

1. _________ . ___________ 3. _________ . ___________

2. _________ . ___________ 4. _________ . ___________

22. PRIOR AUTHORIZATION NUMBER

23. A. DATE(S) OF SERVICE From MM	DD	YYYY	To MM	DD	YYYY	B. PLACE OF SERVICE	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	D. DIAGNOSIS POINTER	E. $ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. RENDERING PROVIDER ID. #
1													
2													
3													
4													
5													
6													

24. PATIENT'S ACCOUNT NO.

25. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

26. TOTAL CHARGE $

27. AMOUNT PAID $

28. BALANCE DUE $

29. SIGNATURE OF PROVIDER (I certify that any supporting documents apply to this bill and are made a part thereof.)

SIGNED ______________________ DATE ___________

30. NAME AND ADDRESS OF OFFICE SUBMITTING CLAIM

31. PROVIDER TYPE
Physician ☐ Optometrist ☐ Psychologist ☐
Dentist ☐ Allied Health ☐ Other: ______________ ☐