Atlantic Medical

Premier Health

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|---|
| POLICY No. |
| CERTIFICATE No. |
| CLAIM No. OFFICE USE ONLY |

ATLANTIC MEDICAL INSURANCE LIMITED, Atlantic House, 2nd Terrace & Collins Avenue,
P.O. Box SS-5915 Nassau, Bahamas. Telephone: (242) 326-8191 Fax: (242) 326-8189

# HEALTH INSURANCE CLAIM FORM

**IMPORTANT:** Proof of claim must be submitted within 90 days of first day of accident or illness

STATE CURRENCY IF NOT $US

## PART 1- EMPLOYEE (to be completed by Employee)

Full Name of Employee/Insured _____
FIRST NAME MIDDLE INITIAL LAST NAME

Full Name of Patient _____

Patient's Mailing Address _____

Patient's Date of Birth: DD MM YY Gender: MALE ☐ FEMALE ☐

Patient's relationship to the Insured: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

Name and Address of Employer _____

If you have any other Health Coverage, enter name of policyholder and policy number.
NAME: POLICY NO.

**TYPE OF CLAIM:** MEDICAL ☐ VISION ☐

Was sickness/injury related to: Patient's Employment: ☐ Traffic Accident: ☐ Pregnancy: ☐ Other: ☐ (give details below)

Details of Claim

**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 person's who treated me and all hospitals and other institutions to furnish full information, including full copies of records regarding this claim to Atlantic Medical Insurance Company.

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** _____ Date DD MM YY

**ASSIGNMENT OF INSURANCE BENEFITS: (Sign only for direct payment to hospital or doctor)**

I hereby authorize payment directly to the hospital and to the physician where applicable, name 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 charges not covered by the Policy.

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** _____ Date DD MM YY

## ATTENDING PHYSICIAN OR SUPPLIER INFORMATION

Date of illness (first symptom) or 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 ☐

Date patient able to return to work DD MM YY

Date of total disability FROM DD MM YY TO DD MM YY

Date of partial disability FROM DD MM YY TO DD MM YY

Was laboratory work performed outside your office? YES ☐ NO ☐

**HOSPITALISATION** Date admitted DD MM YY

Date discharged DD MM YY

Was the following operation(s) to correct a condition which was detrimental to the health of the patient? YES ☐ NO ☐

Diagnosis or nature of illness or injury

Name of referring physician or other source

| Date of service | Place of service | Procedure code | Fully describe procedures, medical services or supplies furnished for each date given | Diagnoses code | Charges | Days of Units | Type of service |
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Physician/Supplier Signature
I certify that the statements to the reverse of this bill and are made a part hereof

Physician/Supplier Name, Address, Zip, Tel. No.

Name/Address of facility where services were rendered if different from above

Total Charges | Amount Paid | Balance Due

Your patient's account number