Completing your Health Insurance Claim Form

The Health Insurance Claim Form must be completed and signed by you and your Attending Physician, who may be a general practitioner, specialist or other qualified provider duly registered with the Medical Board of Trinidad and Tobago or accredited association (please see checklist below to ensure you submit all relevant information claim)

HEALTH INSURANCE CLAIM FORM

Claims must be submitted within 90 days of being incurred and original receipts/itemized bills must be attached.

1. TO BE COMPLETED BY EMPLOYEE / INSURED:

Surname: ________ First Name: ________ Date Of Birth: (d/m/yr): ________

Address: ________

ID No.: ________ Telephone Nos.: ________

Patient's Name ________ Relationship: ________ Date Of Birth: (d/m/yr) ________

When did symptoms of the ailment first appear? ________

Have you ever had this ailment before? If yes, state when and describe ________

CAUSE OF CONDITION:

Is Patient's Condition Related To: (a) Employment? ☐ Yes ☐ No

(b) Auto Accident? ☐ Yes ☐ No

(c) Other Accident? ☐ Yes ☐ No

Details: ________

If Yes, State Name of Employer's Insurer: ________

CO-ORDINATION OF BENEFITS:

Is Patient Covered By Any Other Plans, Which Provide Benefits For This Injury or Sickness? ☐ Yes ☐ No

If "Yes", give (a) Name Of Insurance Company ________

(b) Insured's Name ________

(c) Name of Group or Company Insured Under ________

AUTHORIZATION:

I/we hereby certify that the foregoing answers are true and correct to the best of my/our knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full detailed information (including full copies of their records) regarding this claim

Insured's Signature: ________

Spouse's Signature: ________

Date: ________

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and direct you to pay to ________

all benefits due to me or my covered dependant (s) as a result of this claim.

I understand that I am financially responsible for charges not covered by the policy.

Insured's Signature: ________

Date: ________

2. TO BE COMPLETED BY EMPLOYER / POLICYHOLDER:

Policy Holder: ________ Policy No: ________ Employee Certificate No.: ________ Effective Date: ________

Has employee made claim for Workmen's Compensation? ☐ Yes ☐ No Is he/she entitled to such benefits? ☐ Yes ☐ No

Company's Stamp: ________ Administrator's Signature: ________ Date: ________

3. TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:

Patient's Name: ________

Date Of Birth: (d/m/yr) ________

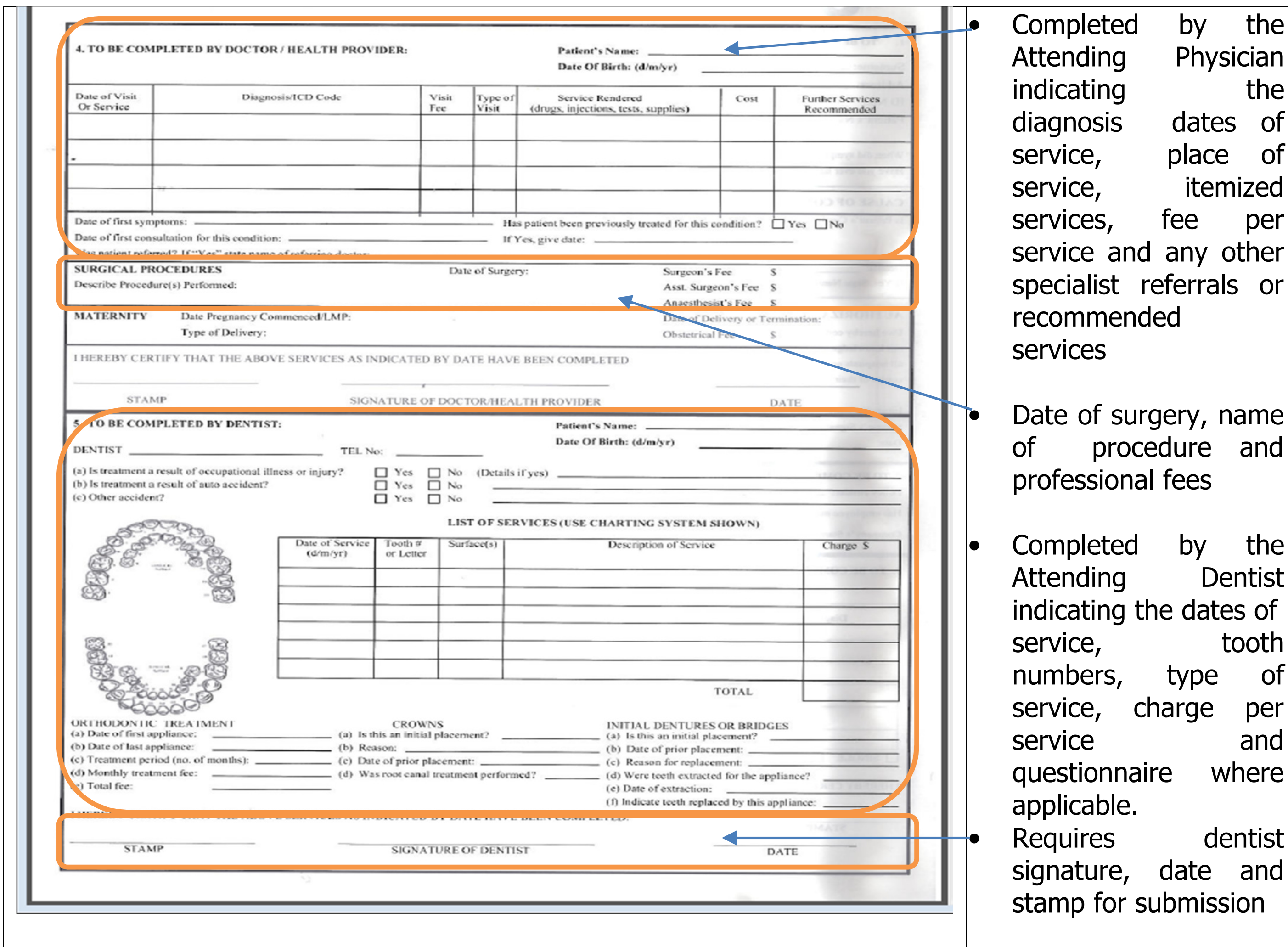
Diagnosis	Date of Service d/m/yr	Description of Service	Charge $

☐ SINGLE ☐ BI-FOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES ☐ SUNGLASSES TOTAL

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED

STAMP SIGNATURE OF OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST DATE

- Insured's Name and Address
- Insured's Date of Birth
- Patient's Name and Date of Birth
- Patient's relation to Insured
- Details of other health insurance coverage in force
- To assign policy benefits to a hospital, doctor, or other provider
- Indicate whether claim is work related or as a result of an accident
- Authorization to release medical information
- Completed by Ophthalmologist or Optician when claiming for vision impairment expenses



4. TO BE COMPLETED BY DOCTOR / HEALTH PROVIDER:

Patient's Name:
Date Of Birth: (d/m/yr)

Date of Visit Or Service	Diagnosis/ICD Code	Visit Fee	Type of Visit	Service Rendered (drugs, injections, tests, supplies)	Cost	Further Services Recommended

Date of first symptoms:
Has patient been previously treated for this condition? ☐ Yes ☐ No
Date of first consultation for this condition:
If Yes, give date:

SURGICAL PROCEDURES
Describe Procedure(s) Performed:
Date of Surgery:
Surgeon's Fee $
Asst. Surgeon's Fee $
Anaesthesist's Fee $

MATERNITY
Date Pregnancy Commenced/LMP:
Type of Delivery:
Date of Delivery or Termination:
Obstetrical Fee $

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED

STAMP SIGNATURE OF DOCTOR/HEALTH PROVIDER DATE

5. TO BE COMPLETED BY DENTIST:

Patient's Name:
Date Of Birth: (d/m/yr)

DENTIST TEL No:

(a) Is treatment a result of occupational illness or injury? ☐ Yes ☐ No (Details if yes)
(b) Is treatment a result of auto accident? ☐ Yes ☐ No
(c) Other accident? ☐ Yes ☐ No

LIST OF SERVICES (USE CHARTING SYSTEM SHOWN)

Date of Service (d/m/yr)	Tooth # or Letter	Surface(s)	Description of Service	Charge $
			TOTAL	

ORTHODONTIC TREATMENT
(a) Date of first appliance:
(b) Date of last appliance:
(c) Treatment period (no. of months):
(d) Monthly treatment fee:
(e) Total fee:

CROWNS
(a) Is this an initial placement?
(b) Reason:
(c) Date of prior placement:
(d) Was root canal treatment performed?

INITIAL DENTURES OR BRIDGES
(a) Is this an initial placement?
(b) Date of prior placement:
(c) Reason for replacement:
(d) Were teeth extracted for the appliance?
(e) Date of extraction:
(f) Indicate teeth replaced by this appliance:

STAMP SIGNATURE OF DENTIST DATE

- Completed by the Attending Physician indicating the diagnosis dates of service, place of service, itemized services, fee per service and any other specialist referrals or recommended services

- Date of surgery, name of procedure and professional fees

- Completed by the Attending Dentist indicating the dates of service, tooth numbers, type of service, charge per service and questionnaire where applicable.
- Requires dentist signature, date and stamp for submission

Completing your Health Insurance Claim Form - Checklist

The omission of important information may affect the timely settlement of your claims. Please use this checklist to ensure that you submit a complete claim.

- Ensure claim form is stamped & completed by the Attending Physician, Dentist, Optician, or other service provider, including the different ailments/diagnoses under treatment and the Provider's/Doctor's Signature and Stamp.

  - All receipts for deposits or part-payments made, where benefits have been assigned to a Medical Provider or Nursing Home MUST be submitted for settlement.
  - All referrals MUST be indicated on the claim form by either the referring doctor or the specialist doctor (indicating the name of the referring doctor).

- Ensure claim form is signed by the Insured (normally the employee) in the appropriate section (Authorization for full payment made OR Assignment of benefits).

- Ensure all expenses and/or services are supported by the relevant receipts or proof of payment (e.g. Credit Card receipt for overseas services).

- All invoices must be accompanied by the respective receipts. Where payment is made but no receipts are issued, the invoices are to be duly authorized and stamped by the Provider/Attending Physician or stamped paid.

- The claim form MUST be completed by the Attending Physician or Specialist indicating the specific diagnosis or diagnoses for all services rendered or drugs prescribed.

- All services rendered or drugs prescribed MUST be medically necessary, that is essential and appropriate for the diagnosis or diagnoses and/or treatment of the specified ailment, sickness or injury. Ensure all drug bills submitted for payment adhere to the under mentioned criteria:

  - Full name of pharmacy or dispensary
  - Full name of the patient
  - Date of the drug bill
  - Name & cost of each drug prescribed
  - Prescription number assigned
  - Full name of the doctor who prescribed the drugs
  - The total cost of the entire prescription

- All hospital bills and/or invoices should be itemised indicating the name and cost of each service performed

- All receipts should state the name of the patient even if the services were paid by another person.

- Ensure that the name given on your application form is the name used when filling in the claim form. For example, if a maiden name was used at the time of the application then this name should also be used when filing the claim. The name indicated on your Healthcare Card is your registered name.

- Complete the front of the claim form indicating specifically:
    - Name of the Insured
    - Name of the Patient
    - Dates of birth of both Insured and Patient
    - Co-ordination of Benefits Section (ONLY if covered by another insurance plan)
    - Policy I.D. Number or Certificate Number (indicated on Healthcare card)

- Ensure that the claim is for full payment on services rendered. Settlement is not made on deposits or part-payments except for Assignment of Benefits.

- The Assignment of Benefits section of the claim form should only be signed if the payment is to be made to someone other than the Insured, for example, a Medical Provider or Nursing Home. In such an instance, you MUST obtain pre-certification/pre-authorization from Colonial Life.

- Copies of claim documents are NOT acceptable for payment unless accompanied by a cover letter indicating the reason for the submission of same. Copied documents will be accepted at the sole discretion of Colonial Life.

- The Tooth Chart on the claim form should be duly completed by the Attending Dentist indicating the tooth numbers under treatment.

For more information, please contact your Plan Administrator or email us at geb@clico.com.

Head Office: 29 St Vincent Street, Port of Spain, Republic of Trinidad and Tobago, W.I. Tel: (868)– 623-1421 Fax: (868)- 627-3821
Email: info@clico.com Website: clico.com