

HEALTH CLAIM FORM

REMEMBER TO ATTACH ORIGINAL RECEIPTS/ITEMIZED BILLS

Notification and proof of claim must be submitted within 90 days

		G	luardian Life of The Caribbe	ean Lim	ited	Notification and	d proof of claim must	be submitted within 90 o	lays		
1. TO	BE CO	OMPLE	TED BY EMPLOYE	R/IN	IDIVIDUAL PO	LICY HOLDER					
POLIC	POLICY NO. POLICY HOLDER				ICY HOLDER		ADMINISTRATOR'S S	INISTRATOR'S SIGNATURE			
ID#											
2. TO	BEC	OMPLE	TED BY EMPLOYE	E/IN	ISURED (PLEA	SE PRINT)					
EMPL	OYEE'S	S / INSU	RED'S NAME:		PATIENT'S NAM	AME: NAME OF SPOUSE'S EMPLOYER:					
					DATE OF BIRTI	H:					
ADDRESS: IS PATIENT'S						CONDITION RELATED TO: a. EMPLOYMENT DYES DNO					
					b. AUTO ACCID	ENT DYES DI	O c. OTHER	ACCIDENT DYES	NO		
TELE	PHONE	NO:			IF YES, GIVE D	ETAILS:				PER ANALYSIS AND ADDRESS OF THE PERSON NAMED IN COLUMN ASSESSMENT OF THE PERSO	
s pati	ient cove	ered thro	ough any other plans (in	ncludir	ng auto insurance)	which provide medic	al or dental benefits or s	services?	OND		
If "YE	S". give	(a) Nam	e of Insurance Compa	nv			×	The state of the s			
174 Olumb											
	I he	reby aut	horize and direct you to	o pay i	to						
		enefits	accruing to me as a res	sult of	this claim to the ex	ktent of bills submitted	I.		Ann a feet a set		
		А	UTHORIZATION: There	eby au	itnorize the doctor	to release any inform	lation acquired in the co	urse of my examination or	treatment.		
	Insu	red's Sig	gnature			Patient's	Signature		_Date		
3. TO	BEC	OMPLE	TED BY DOCTOR/	HEAL	TH PROVIDER						
-	nt's Nam						Name and Address of	Doctor / Health Provider:			
Diagn	nosis or I	Nature o	of Illness or Injury (ICD	CODE	:)						
1.				2.						- Annual Control of the Control of t	
3.				4.			GIVE NAME OF REF	ERRING PHYSICIAN			
		ue to Pr	egnancy? ☐ Yes ☐ N		If you give approx	ximate date of last mo	Inthly period:			AUTO-COMMISSION	
	-		TED BY DOCTOR	-			itany period.				
	of first sy						reviously treated for this	condition? Yes [□ No		
Date	of first co	onsultati	on for this condition:			If yes give date:					
	A		В		T	C C	I D	I F			
	Date		Place of Service	9		Procedures, Service	Diagnosis	Charges	\$		
D	M	Y	(OFFICE/HOME/HO	OSP).		(Explain unusual circumstances)		1, 2, 3, 4			
		-						***************************************			
-			Volume in the second se								
FURTHER SERVICES RECOMMENDED				ED	SURGICAL PROCEDURE				(\$)		
									Charges		
						Date of Operation Type of Operation					
										1.5	
				The section of the se		Name of Surgeon					
						Name of Assistant S	urgeon				
						Name of Anesthetist			Derson etas-		
								TOTAL			
			I HEREBY CER	RTIFY	THAT THE ABOVE	SERVICES AS INDICAT	ED BY DATE HAVE BEEN	COMPLETED			
	-		Stamp		The second secon	Signature of Docto Date					
			otarip			Oly	mandle of brother	U	WI C		

Daily hospital charge for patient (\$) from 10 Operation or delivery room (state type of operation) Hospital Services Name of Admitting Doctor 6. TO BE COMPLETED BY LABORATORY / X-RAY DEPARTMENT Date and type (\$) of test(\$) P. TO BE COMPLETED BY DENTIST DENTIST If YES, ENTER BRILL IF CROWN, was tooth badly broken down? Is treatment result of a like so rinjury? Is treatment result of a like so rinjury? Is treatment result of a nother plan? Other accident? If PROSTHESIS, IS THIS VERY SERVED DATE OF EXTRACTIONS OF TEETH IF YES, GIVE DATE OF EXTRACTIONS OF TEETH OPPOSITE OF SERVICE DESCRIPTION OF TEETH DESCRIPTION OF TEETH DESCRIPTION OF TEETH DESCRIPTION OF SERVICE DESCRIPTION OF TEETH DESCRIPTION OF TEETH	FYES, ENTER BRIEF DESCRIPTION AND DATES BELOW: If CROWN, was tooth Yes No Is treatment result of auto accident? Yes No Is treatment for Yes Yes No Is the treatment for Yes No Yes	5. TO BE COMPLETED BY H	OSPITAL	- i - i - i - i - i - i - i - i - i - i					
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(B) FRAMES (C) LENSES (PLEASE SPECIFY TYPE BELOW) (D) TINTING SINGLE BI-FOCAL MULTI-FOCAL LENTICULAR CONTACT LENSE a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus	(B) FRAMES (C) LENSES (PLEASE SPECIFY TYPE BELOW) (D) TINTING MULTI-FOCAL LENTICULAR CONTACT LENSES cribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia: Yes No at least the 20/70 level by spectacle lenses? Yes No at least the 20/70 level by contact lenses? Yes No asses? Yes No asses. Yes Yes No asses. Yes Yes Yes No asses. Yes	Diagnosis							
(C) LENSES (PLEASE SPECIFY TYPE BELOW) (D) TINTING SINGLE BI-FOCAL MULTI-FOCAL LENTICULAR CONTACT LENSE a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus	(C) LENSES (PLEASE SPECIFY TYPE BELOW) (D) TINTING MULTI-FOCAL		The second secon						
(D) TINTING SINGLE BI-FOCAL MULTI-FOCAL LENTICULAR CONTACT LENSE a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus	MULTI-FOCAL LENTICULAR CONTACT LENSES coribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia: Yes No at least the 20/70 level by spectacle lenses? At least the 20/70 level by contact lenses? SSES? ALASSES? TOTAL EXPENSES MUST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON			(B) FRAMES					
SINGLE BI-FOCAL MULTI-FOCAL LENTICULAR CONTACT LENSE a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus	MULTI-FOCAL			(C) LENSES (P	LEASE SPECIF	Y TYPE BELOW)			
a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus	scribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia:			(D) TINTING					
	at least the 20/70 level by spectacle lenses? At least the 20/70 level by contact lenses? SSES? SLASSES? TOTAL EXPENSES JUST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON	SINGLE BI-FOCAL	☐ MULTI-FOCAL	☐ LENTICE	ULAR 🔲	CONTACT LENSES			
Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses?	TOTAL EXPENSES WEST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON					rring, keratoconus or aph			
Can visual acuity be improved by up to at least the 20/70 level by contact lenses? b) Are these PRESCRIPTION SUN GLASSES?	SLASSES? TOTAL EXPENSES UST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON	Can visual acuity be improved to by Are these PRESCRIPTION SUI	by up to at least the 20/7 N GLASSES?				Yes No	0	
Replacement of LOST or DAMAGED GLASSES?	IUST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON	Replacement of LOST or DAMA	GED GLASSES?				☐ Yes ☐ No	0	
								3	
9. CERTIFICATION - THE FORM MUST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHO	CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED	9. CERTIFICATION - THE FO	HM MUST BE SIGN	IED BY DENTI	ST / OPTOME	THIST / AUTHORIZE	D PERSON		
		St	amp		Sign	ature of Doctor	-0	Date	