Guardian Group

Guardian Life of The Caribbean Limited

# HEALTH CLAIM FORM

## REMEMBER TO ATTACH ORIGINAL RECEIPTS/ITEMIZED BILLS

**Notification and proof of claim must be submitted within 90 days**

## 1. TO BE COMPLETED BY EMPLOYER / INDIVIDUAL POLICY HOLDER

| POLICY NO. | POLICY HOLDER | ADMINISTRATOR'S SIGNATURE |
|---|---|---|
| ID# | | |

## 2. TO BE COMPLETED BY EMPLOYEE / INSURED (PLEASE PRINT)

| EMPLOYEE'S / INSURED'S NAME: | PATIENT'S NAME: | NAME OF SPOUSE'S EMPLOYER: |
|---|---|---|
| | DATE OF BIRTH: | |
| ADDRESS: | IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT ❑YES ❑NO | |
| | b. AUTO ACCIDENT ❑YES ❑NO c. OTHER ACCIDENT ❑YES ❑NO | |
| TELEPHONE NO: | IF YES, GIVE DETAILS: | |

Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? ❑ YES ❑ NO

If "YES", give (a) Name of Insurance Company _____

(b) Name of Group of Company insured under _____

I hereby authorize and direct you to pay to _____ all benefits accruing to me as a result of this claim to the extent of bills submitted.

AUTHORIZATION: I hereby authorize the doctor to release any information acquired in the course of my examination or treatment.

Insured's Signature _____ Patient's Signature _____ Date _____

## 3. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER

| Patient's Name: | Name and Address of Doctor / Health Provider: |
|---|---|
| Diagnosis or Nature of Illness or Injury (ICD CODE)<br>1. 2.<br>3. 4. | GIVE NAME OF REFERRING PHYSICIAN |

Is condition due to Pregnancy? ❑ Yes ❑ No If yes, give approximate date of last monthly period:

## 4. TO BE COMPLETED BY DOCTOR - MEDICAL / SURGICAL TREATMENT

| 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: _____ |

| A Date D | M | Y | B Place of Service (OFFICE/HOME/HOSP). | C Procedures, Services or Supplies (Explain unusual circumstances) | D Diagnosis 1, 2, 3, 4 | E Charges | $ |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| FURTHER SERVICES RECOMMENDED | SURGICAL PROCEDURE | Charges | ($) |
|---|---|---|---|
| | | | |
| | Date of Operation | | |
| | Type of Operation | | |
| | Name of Surgeon | | |
| | Name of Assistant Surgeon | | |
| | Name of Anesthetist | | |
| | TOTAL | | |

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

Stamp _____ Signature of Doctor _____ Date _____

Jeffrey & Jeffrey Insurance Agency, Agents for Guardian Life of the Caribbean, Choc Estate, Castries, St. Lucia
Tel: (758) 452-3892 Fax: (758) 453-1844 Email: gloc@jeffinsure.biz

## 5. TO BE COMPLETED BY HOSPITAL

No. of days confined ..... ❑ Private ❑ Semi-private ❑ Ward | Charge $

Daily hospital charge for patient ($ ) from ..... to .....

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 (s) of test(s) | Charge $

.....

.....

## 7. TO BE COMPLETED BY DENTIST

DENTIST

ADDRESS

TEL#

IF YES, ENTER BRIEF DESCRIPTION AND DATES BELOW:

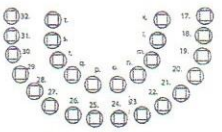
| | | |
|---|---|---|
| If CROWN, was tooth badly broken down? | ❑ Yes ❑ No | |
| Is treatment result of occupational illness or injury? | ❑ Yes ❑ No | |
| Is treatment result of auto accident? Other accident? | ❑ Yes ❑ No | |
| Are any services covered by another plan? | ❑ Yes ❑ No | |
| Is the treatment for Orthodontics? | ❑ Yes ❑ No | |

| FIRST VISIT DATE dd mm yy | PLACE OF TREATMENT - Office ❑ Hosp ❑ Other ❑ | X-RAYS OR MODELS ENC? ❑ Yes ❑ No | How Many? |
|---|---|---|---|
| | | | |

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ❑ Yes ❑ No

IF YES, GIVE DATE OF EXTRACTIONS OF TEETH BEING REPLACED

IF NO, GIVE REASON FOR REPLACEMENT AND DATE OF PRIOR PLACEMENT:



INDICATE MISSING TOOTH WITH AN "X"

**EXAMINATION AND TREATMENT PLAN, LIST IN ORDER. USE CHARTTING SYSTEM SHOWN.**

| Date of Service (dd/mm/yy) | Tooth # or Letter | Surface | Description of Service | Charge $ |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

❑ PREDETERMINATION ❑ ACTUAL TOTAL

## 8. TO BE COMPLETED BY OPTOMETRIST / OPHTHALMOLOGIST

| Diagnosis | Date of Service (dd/mm/yy) | Description of Service | Charge $ |
|---|---|---|---|
| | | (A) EXAMINATION | |
| | | (B) FRAMES | |
| | | (C) LENSES (PLEASE SPECIFY TYPE BELOW) | |
| | | (D) TINTING | |

❑ SINGLE ❑ BI-FOCAL ❑ MULTI-FOCAL ❑ LENTICULAR ❑ CONTACT LENSES

(a) IF CONTACT LENSES, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia: ❑ Yes ❑ No
Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? ❑ Yes ❑ No
Can visual acuity be improved by up to at least the 20/70 level by contact lenses? ❑ Yes ❑ No
(b) Are these PRESCRIPTION SUN GLASSES? ❑ Yes ❑ No
Replacement of LOST or DAMAGED GLASSES? ❑ Yes ❑ No

TOTAL EXPENSES

## 9. CERTIFICATION - THE FORM MUST BE SIGNED BY DENTIST / OPTOMETRIST / AUTHORIZED PERSON

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

Stamp | Signature of Doctor | Date