HEALTH INSURANCE CLAIM FORM

1. Patient's Name (first, middle initial, last)	2. Patient's Birth date DD/MM/YY	3. Insured's Name (first, middle initial, last)
4. Patient's full address & phone number	5. patient's sex: ☐ Male ☐ Female 7. Relationship to insured ☐ self ☐ spouse ☐ child ☐ other	6. Is dependent a full-time student? ☐ Yes ☐ No If YES name and address of school
9. Does patient have other health insurance? ☐ Yes ☐ No If YES, give name of Insurance company, address, policy and name of Insured.	10. Was condition related to: A. Patient's employment ☐ Yes ☐ No B. An accident ☐ Yes ☐ No	11. If an accident, give date and brief details.

12. **AUTHORIZATION** I certify that the information furnished by me in support of this claim is true and correct. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, pharmacist, educational institution or other person to release any formation requested with respect to this claim. A photocopy or other reproduction of this release will be as valid as the original.

SIGNATURE OF THE PATIENT: **DATE:**

13. **ASSIGNMENT OF BENEFITS TO PHYSICIAN** I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical benefits, if any, otherwise payable to me for his services as described Below but not to exceed the reasonable customary charge for those services.

SIGNATURE OF INSURED: **DATE:**

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of illness (first symptom) injury or pregnancy (LMP)	15. Date patient first consulted you for this condition:	16. Has patient ever had same or similar symptoms prior to this visit? ☐ Yes ☐ No

17. Date patient able to return to work	18. Type of disability ☐ Partial ☐ Total	Disabled from: (DD/MM/YY)	Disable to: (DD/MM/YY)	19. Hospitalized from: (DD/MM/YY)	Hospitalized to: (DD/MM/YY)

20. Name and address of referring physician	21. Name and address of facility where services rendered

22. Please list any other insurance companies with which you have filed this claim.

23. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to numbers 1,2,3 etc, or DX code

1.

2.

3.

4.

24. Date of Service	Place of Service	Procedure Code	Description of Procedure Service or Supply	Diagnosis Code	25. Charges

26. Signature of Physician or Supplies, Date (DD/MM/YY)	27. Name, Address of Physician or supplier	28. Total Charge	29. Paid	30. Due
31. Patient's Account #		32. Your ID#	33. Accept Assignment ☐ Yes ☐ No	