NAGICO INSURANCES

HEALTH CLAIM FORM

Remember to attach original receipts/itemized bills
Notification and proof of claim must be submitted within 90 days

☐ HEALTH ☐ VISION ☐ DENTAL

1. TO BE COMPLETED BY EMPLOYER/INDIVIDUAL POLICYHOLDER		Sign below if claim is being processed by an HR Officer
Policy NO.:	Policy Holder:	
ID#:		

2. TO BE COMPLETED BY EMPLOYEE/INSURED (PLEASE PRINT)			
Employee's/Insured's name:		Patient's Name: Date of Birth:	Name of spouse's employer:
Address:	Telephone No.:	Is patient's condition related to: a. Employment ☐ Yes ☐ No b. Auto accident ☐ Yes ☐ No c. Other Accident ☐ Yes ☐ 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 or 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.

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

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

3. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER	
Patient's Name:	
Diagnosis or nature of illness or injury (ICD CODE) 1. 3. 2. 4.	Name & Address of Doctor/Health Provider: 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	B	C	D	E	
Date DD/MM/YY	Place of Service (Office/Home/Hosp.	Procedures, Services or supplies (Explain unusual circumstances)	Diagnosis 1,2,3,4	Charges $	¢

Further services recommended	Surgical procedure	$	¢
	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 _____

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED UNLESS ASSIGNED.

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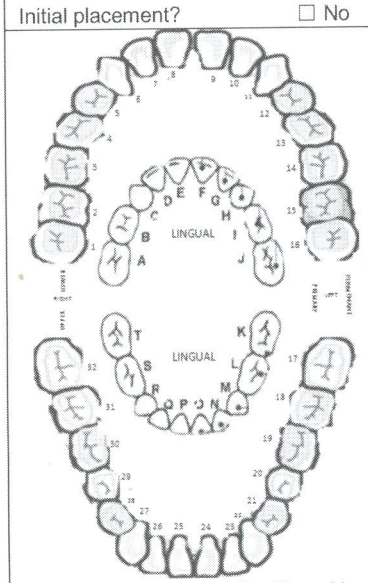
5. TO BE COMPLETED BY HOSPITAL	Charges $	Charges ¢
NO. of days confined: ☐ Private ☐ Semi-private ☐ Ward		
Daily hospital charge for patient: ($) From: To:		
Operation or delivery room (state type of operation):		
Hospital services:		
Name of admitting Doctor:		

6. TO BE COMPLETED BY LABORATORY.X-RAY DEPARTMENT	$	¢
Date and type(s) of test(s)		

7. TO BE COMPLETED BY DENTIST

Dentist:	If Yes, enter brief description and dates below
	If crown, was tooth badly broken down? ☐ Yes ☐ No
Address:	Is treatment result of occupational illness or injury? ☐ Yes ☐ No
Telephone No.:	Is treatment result of auto accident? Other Accident? ☐ Yes ☐ No
First visit date (dd/mm/yy) / Place of treatment: ☐ Hospital ☐ Office ☐ Other	X-rays or models enclosed? ☐ 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 teeth with an X

Examination and treatment plan. List in order. Use charting system shown

Date of service (dd/mm/yy)	Tooth # Or Letter	Surface	Description of service	Charges $	Charges ¢
☐ Predetermination ☐ Actual			**TOTAL**		

8. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST

Diagnosis	Date of service (dd/mm/yy)	Description of service	Charges $	Charges ¢
		(A) Examination		
		(B) Frames		
		(C) Lenses (please specify type below)		
		(D) Tinting		

☐ Single ☐ Bi-focal ☐ Lenticular ☐ Contact Lenses

(a) If Contact Lenses, were they prescribed 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. THIS FORM MUST BE SIGNED BY DENTIST/OPTOMOTRIST/AUTHORISED PERSON

I hereby certify that the above services as indicated by date have been completed.

Stamp _____ Signature of provider _____ Date _____