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:

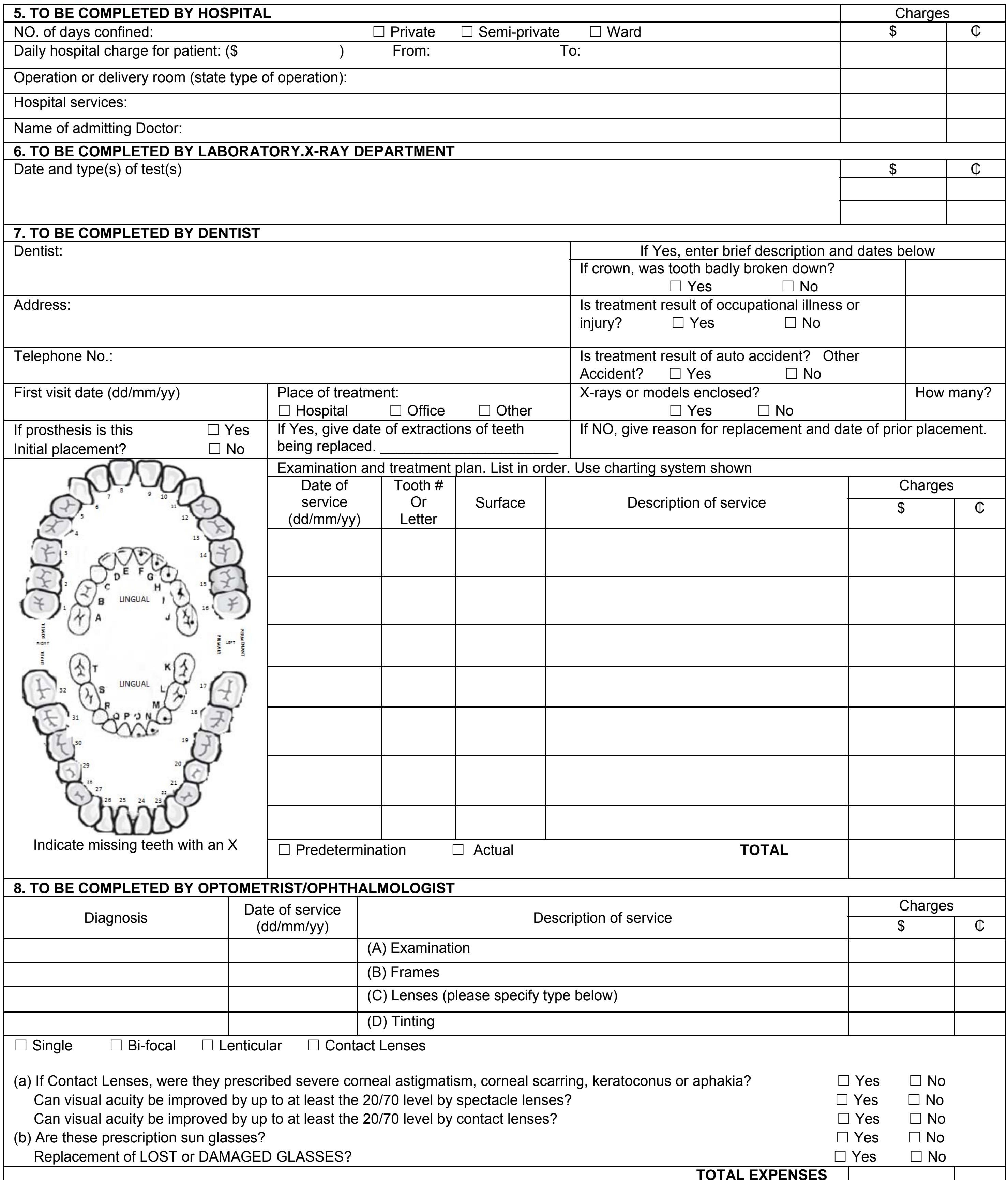
A	B	C	D	E	
Date DD/MM/YY	Place of Service (Office/Home/Hosp.	Procedures, Services or supplies (Explain unusual circumstances)	Diagnosis 1,2,3,4	Charges	
				$	₵
Further services recommended		Surgical procedure		$	₵
		Date of Operation:			
		Type of Operation:			
		Name of Surgeon:			
		Name of Assistant 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.

NAGICO INSURANCES



5. TO BE COMPLETED BY HOSPITAL	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