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	6. Patient's BAF Group/ID number
7. Relationship to insured self ☐ spouse ☐ child ☐ other ☐	8. 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 ☐ B. Auto Accident ☐ Pregnancy ☐ Substance abuse ☐ Other		11. Please provide 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 reprcduction 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 **Medical Services Provider**.

SIGNATURE OF INSURED: **DATE:**

PHYSICIAN OR SUPPLIER INFORMATION

14. Date 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. If Patient was unable to work due to this illness give date(s):	18. If patient was hospitalized for this illness give date(s):	
19. Name and address of referring physician	20. Name and address of facility where services rendered	

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

Diagnosis or nature of illness or injury.

Date of Service DD/MM/YYYY	Place of Service	Procedure Code	Description of Procedure Service or Supply	Diagnosis Code	Charges

I CERTIFY THAT THE INFORMATION FURNISHED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Physician or Supplies, Date (DD/MM/YY)	Name, Address of Physician or supplier	Total Charge	Paid	Due
Patient's Account #	International Medical Group P.O. Box 30073 Grand Cayman KY1-1201 Cayman Islands Tel: (345) 945-2881 Fax: (345) 949-4341	Your ID#	Accept Assignment? ☐ Yes ☐ No	