N.E.M (WEST INDIES) INSURANCE LIMITED
c/o FIDELITY INSURANCE (CAYMAN) LTD.
P.O. BOX 2174
36A DR. ROY'S DRIVE
GRAND CAYMAN, KY1-1105
CAYMAN ISLANDS
Tel: (345) 949-5836 Fax: (345) 949-6747

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File#) GROUP ☐ HEALTH PLAN (SSN or ID) FECA ☐ BLK LUNG (SSN) OTHER ☐ (ID)

1a. INSURED I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME
LAST NAME, FIRST NAME, MIDDLE INITIAL

3. PATIENT'S BIRTH DATE MM - DD- YY SEX M ☐ F ☐

4. INSURED'S NAME
LAST NAME, FIRST NAME , MIDDLE INITIAL

5. PATIENTS ADDRESS (No. , Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐
Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME
LAST NAME, FIRST NAME, MIDDLE INITIAL

a. OTHER INSURED'S POLICY OR GROUP NO.#

b. OTHER INSURED'S DOB SEX ☐ M ☐ F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION REALTED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) ________
c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM- DD- YY SEX M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN
☐ YES ☐ NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for service described below.

SIGNED ______________________

14. DATE OF CURRENT : ILLNESS (First symptom) INJURY (Accident) OR PREGNANCY (LMP) MM- DD- YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM-- DD-- YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM-- DD-- YY TO MM-- DD-- YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE.

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.
FROM MM-- DD-- YY TO MM-- DD-- YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ______________ 3. ______________
2. ______________ 4. ______________

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE FROM	TO	Place Of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNIT	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM-DD-YY	MM-DD-YY											
MM-DD-YY	MM-DD-YY											
MM-DD-YY	MM-DD-YY											
MM-DD-YY	MM-DD-YY											
MM-DD-YY	MM-DD-YY											
MM-DD-YY	MM-DD-YY											

25. FEDERALTAX I.D NUMBER SSN ☐ EIN ☐

26. PATIENTS ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For Govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGES $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICE WERE RENDERED (If other than home or office)

International Medical Group
P.O. Box 30073
Grand Cayman KY1-1201
Cayman Islands
Tel: (345) 945-2881 Fax: (345) 949-4341

33. PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) PLEASE PRINT OR TYPE

FORM HCFA -1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION