Generali Worldwide Health Insurance Claim Form

For Medical, Dental and Vision Claims

Claim Number:

GROUP HEALTH PLAN OTHER

______________________________(SSNor ID)______________________________(ID)

1. INSURED'S ID NO. (FOR PROGRAM IN ITEM 1)
____ ____ ____ - ____ ____ - ____ ____ ____ ____

2. PATIENT'S NAME (Last Name, First Name, Middle Name)

3. PATIENT'S BIRTH DATE SEX M____ F____

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

CITY STATE

ZIP CODE TELEPHONE (include area code)

6. PATIENT'S RELATIONSHIP TO INSURED

8. PATIENT STATUS

Single ________ Married _______ Other ________

Employed _____ Full-time Student _______ Part-time Student ________

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

CITY STATE

ZIP CODE TELEPHONE (include area code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX M____ F____

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. PATIENT'S CONDITION RELATED TO

a. EMPLOYMENT? (Current or Previous)
____YES ____NO

b. AUTO ACCIDENT? PLACE (state)
____YES ____NO ________________

c. OTHER ACCIDENT?
____YES ____NO

11. INSURED'S POLICY GROUP OR FECA NO.

a. INSURED'S DATE OF BIRTH SEX M____ F____

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME
Generali Worldwide

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
____YES ____NO If Yes, return to and complete item 9 a-d

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 services described below.

SIGNED ______________________________

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES UNABLE TO WORK IN CURRENT OCCUPATION
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NO. OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LABS? $CHARGES (Indicate Currency)
____YES ____NO

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

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

23. PRIOR AUTHORIZATION NUMBER

24. A		B	C		D	E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM	TO	TYPE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS	MOD	DX CODE	Procedure		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	$ CHARGES

25. FEDERAL TAX ID NUMBER
________________SSN________________EIN

26. PATIENT'S ACCOUNT NO.

26. ACCEPT ASSIGNMENT?
____YES ____NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED__________________ DATE_________

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

31. SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

GW Cay HIC 07/08

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