CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

HEALTH BENEFITS PRE-DETERMINATION FORM

Form No. GIS04 Aug 10, 2010

A. INSURED INFORMATION

Patient Name:	Date of Birth:	Sex: [ ] Male [ ] Female
Patient Address:	Patient Insured Status: [ ] Self [ ] Dependent	
Enrollee Name:	Member ID:	
Policy ID:	Policyowner:	

B. HEALTH SERVICES TO BE FURNISHED *(To be completed by Health Provider)*

Provider Name:	Telephone No:
Provider Address:	Fax No:

Name and Address of Referring Physician, if applicable:

Diagnosis(es):

Date first symptoms appeared:	Date you first saw patient:	Date(s) patient previously had similar condition, if applicable:
For pregnancy, date of last menstrual period:	Provider HPB Registration No:	

DESCRIPTION OF SCHEDULED HEALTH SERVICE(S) AND/OR TREATMENT	Diag Code	Proc Code	ESTIMATED CHARGES (CI$)	INS. CO. USE ONLY

I certify that the information furnished above is true and correct.	TOTAL CHARGE:		
	TO BE PAID BY PATIENT:		
	BALANCE TO BE PAID BY INSURANCE:		

_____ Provider's Signature

_____ Date

C. CAYMAN FIRST'S RESPONSE

Based on the information provided, this patient's insurance plan will cover _____ of the estimated expenses.

Should the actual cost exceed this estimate by more than 10%, please provide a detailed report when submitting the claim.

_____ Authorised Signature

_____ Date

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