CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

MEDICAL INSURANCE CLAIM FORM

Form No. GIS20 Aug 10, 2010

Please attach original bills

SECTION A. ENROLLEE AND PATIENT INFORMATION

PATIENT'S CGI IDENTIFICATION NUMBER:	**PATIENT'S DATE OF BIRTH:**	**CGI POLICY ID/ POLICYOWNER/ PLAN SPONSOR:**
PATIENT'S NAME (Last, First, Middle):	**PATIENT'S RELATION TO ENROLLEE:** [ ] Self [ ] Spouse [ ] Child [ ] Other	**ENROLLEE'S NAME (Last, First, Middle):**
PATIENT'S MAILING ADDRESS (P O Box):	**PATIENT'S STATUS:** [ ] Single [ ] Married [ ] Other [ ] Employed [ ] Student [ ] Other	**ENROLLEE'S MAILING ADDRESS (P O Box):**
PATIENT'S STREET ADDRESS:	**PATIENT'S CONDITION RELATED TO:** [ ] Employment, date: _____ [ ] Auto accident, date: _____ [ ] Other emergency, date:	**ENROLLEE'S STREET ADDRESS:**
PATIENT'S PHONE & FAX NUMBERS:	[ ] Pregnancy, LMP: _____ [ ] Substance abuse, date:	**ENROLLEE'S PHONE & FAX NUMBERS:**
PATIENT'S OTHER HEALTH INSURANCE (if any):	[ ] Other, date: _____	**ENROLLEE'S OTHER HEALTH INSURANCE (if any):**

PATIENT'S AUTHORISATION

I authorise Cayman First Insurance Company Limited to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.

Signature _____ Date _____

PAYMENT ASSIGNMENT

I authorise Cayman First Insurance Company Limited to pay the proceeds of this claim to the undersigned Medical Services Provider.

Signature _____ Date _____

SECTION B. MEDICAL PROVIDER INFORMATION

DATE OF FIRST SYMPTOM OR LMP:	**IF PATIENT HAD SUFFERED SAME OR SIMILAR ILLNESS BEFORE, GIVE DATE(S):**	**IF PATIENT WAS UNABLE TO WORK DUE TO THIS ILLNESS, GIVE DATE(S):**
NAME AND ADDRESS OF REFERRING OR PREVIOUS PHYSICIAN, OR OTHER SOURCE:		**IF PATIENT WAS HOSPITALISED FOR THIS ILLNESS, GIVE DATE(S):**
DATE YOU FIRST TREATED PATIENT FOR THIS ILLNESS:	**WAS OUTPATIENT DIAGNOSTIC SERVICES ORDERED, OR MEDICATION PRESCRIBED?** [ ] Yes [ ] No	**NATURE OF ACCIDENT, IF APPLICABLE:**

DIAGNOSIS, ILLNESS OR INJURY*		TREATMENT SERVICES*				
CODE	**DESCRIPTION**	**DATE(S) From**	**To**	**CODE**	**DESCRIPTION**	**CHARGE CI$**

* If required, additional information may be detailed on the reverse side of this form.

PATIENT ACCOUNT NO:	**ACCEPT ASSIGNMENT?** [ ] Yes [ ] No	**TOTAL CHARGE: CI$**	**PATIENT RESPONSIBILITY: C**	**BALANCE OUTSTANDING: CI$**

I certify that the information furnished above is true and correct to the best of my knowledge.

PROVIDER NAME:	**PROVIDER TELEPHONE NUMBER:**	**PROVIDER REGISTRATION NUMBER:**
PROVIDER ADDRESS:	**PROVIDER'S SIGNATURE:**	**DATE:**

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Please provide additional details here.

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