CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

Form No. GIS07 Aug 10, 2010

INSURANCE CLAIM FORM FOR VISION CARE

A. CLAIMANT INFORMATION *(To be completed by Insured)*

Patient Name:	Date of Birth:	Sex: [ ] Male [ ] Female
Patient Address:		Patient Insured Status: [ ] Self [ ] Dependant
Enrollee Name:	Certificate Number:	Dependant Number:
Group Policy Number:	Group Name:	

CLAIMANT'S AUTHORISATION

I authorise Cayman First 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 to pay the proceeds of this claim to the undersigned Vision Care Provider(s).

Signature _____ Date _____

B. VISION CARE SERVICES PROVIDED *(To be completed by Ophthalmologist or Optometrist)*

Vision Care Provider Name:	Telephone No.:
Vision Care Provider Address:	
Has cataract surgery been performed? [ ] No [ ] Yes	Does patient require a prescription change at this time? [ ] No [ ] Yes
Diagnosis:	
Date of Service:	

	PRESCRIPTION						
Visual acuity	Sphere	Cylinder	Axis	Prism	Base		
	R.E. -	-				**FEE: $**	
	L.E. -	-				**PAID BY PATIENT: $**	
	READING ADD	R.E.	+ '	L.E.	+ '	**BALANCE DUE: $**	

I hereby certify that this is a true statement of treatment and services rendered.

Signature of Ophthalmologist/ Optometrist _____ Date _____

C. VISION CARE PRESCRIPTION FILLED *(To be completed by Optician or Vision Care Laboratory)*

Optician Name:	Telephone No.:
Optician Address:	

PROFESSIONAL SERVICES

SERVICES RENDERED/ ITEMS SUPPLIED		FEES $	INS. CO. ONLY
Frame Manufacturer Name:	Model or Cat. No. and Size:		
Lenses: [ ] None [ ] Single [ ] Bifocal [ ] Trifocal [ ] Lenticular [ ] Other _____			
Contact Lenses: [ ] None [ ] Therapeutic [ ] Non-Therapeutic [ ] Hard Lenses [ ] Soft Lenses			
I hereby certify that this is a true statement of treatment and services rendered.	**TOTAL FEES:**		
	PAID BY PATIENT:		
Signature of Optician/ Vision CareLab Manager _____ Date _____	**BALANCE DUE:**		