Colina Imperial. Insurance Ltd.

HEALTH INSURANCE CLAIM FORM

PLEASE COMPLETE EACH NUMBERED ITEM - FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

(CHECK APPLICABLE PROGRAM BLOCK) ☐ PPO ☐ NON-PPO

A. (TO BE COMPLETED BY INSURED)

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4. PATIENT'S ADDRESS

TELEPHONE NO.

5. PATIENT'S SEX — MALE ☐ FEMALE ☐

6. INSURED'S I.D. NO.

7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. & GROUP NAME

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:

A. PATIENTS EMPLOYMENT — YES ☐ ☐ NO

B. ACCIDENT — AUTO ☐ ☐ OTHER

11. INSURED'S ADDRESS

TELEPHONE NO.

EMPLOYMENT STATUS ☐ ACTIVE DUTY ☐ RETIRED

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED

DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

B. (TO BE COMPLETED BY PHYSICIAN OR SUPPLIER)

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16. A. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM — THROUGH

DATES OF PARTIAL DISABILITY — FROM — THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATE — ADMITTED — DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

24. A. DATE OF SERVICE FROM	TO	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS)

DATE:

26. ACCEPT ASSIGNMENT — YES ☐ ☐ NO

30. YOUR SOCIAL SECURITY NO.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIANS SUPPLIERS AND /OR GROUP NAME, ADDRESS, AND TELEPHONE NO.

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS: