Generali Worldwide

Group Health Insurance – Claim Form
For Medical, Dental and Vision Claims

Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

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. PATIENT'S CONDITION RELATED TO **a)** EMPLOYMENT? (Current or Previous) _____YES _____NO **b)** AUTO ACCIDENT? _____YES _____NO PLACE (state) _____ **c)** OTHER ACCIDENT?_____YES _____NO	**10.** 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	
11. PATIENT'S 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____/____/_____	**12.** INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned Physician or supplier for services described below. SIGNED _____	
13. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) ____/____/_____	**14.** IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE ____/____/_____	**15.** NAME OF REFERRING PHYSICIAN OR OTHER SOURCE _____
16. OUTSIDE LABS? $CHARGES (Indicate Currency) _____YES _____NO	**17.** DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3,4,5 OR 6 TO ITEM 18B BY LINE) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	

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

19. FEDERAL TAX ID NUMBER _____SSN_____EIN	**20.** PATIENT'S ACCOUNT NO.	**21.** ACCEPT ASSIGNMENT? ____ YES____NO	**22.** TOTAL CHARGE	**23.** AMOUNT PAID	**24.** BALANCE DUE
25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED_____ DATE ____ /____ /_____	**26.** NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	**27.** SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#			

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Regulated in the Cayman Islands as a licensed insurer by the Cayman Islands Monetary Authority.
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