

Generali Worldwide

Health Insurance – Vision Claim Form



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

INSTRUCTIONS FOR FILING A VISION CLAIM

1. Please type or print and include all requested information
2. A separate claim form must be completed for each family member who is making a claim
3. Attach all original fully itemized vision bill(s) to the completed form
4. SECTIONS A, B, C, D, E and F – must be completed by the Insured (Employee)

NOTE: This section must be completed in its entirety in order to process the claim

5. SECTIONS G and H – must be completed by the Provider of Services

NOTE: If you have a fully itemized vision care bill, the Provider of Services does not need to complete Sections G and H of the Vision Claim Form, but all documentation, fully itemized medical bill(s) and receipt(s) must include:

- Patient Name
- Date of Service (date the appliance (i.e. glasses) were delivered to the patient)
- Type of Lens dispensed (i.e. contacts, single vision, bifocal, etc)
- Type of Frame (i.e. wire, plastic, etc)
- Billed Charges and the Currency for each Service/ Supply Provided

If all of the above information is not indicated on the bill(s)/ receipt(s), then the Provider of Services must complete Section G.

All documentation and related correspondence must be sent to:

Generali Worldwide
P.O. Box 306
266 Elmwood Avenue, Buffalo NY 14222
Tel: +1 905 762 5193 Fax: +1 905 762 5194

generali-healthcare.com

ONLINE ACCESS

To view your information online, please login to <https://services.hi-techhealth.com/bah/pages/signon.shtml> and enter in your username and password.

If you are logging in for the first time, please follow the instructions below:

- Your default Username is your Member ID number or your National Insurance Board number
- Your default Password is your date of birth in an eight digit format (MM/DD/YYYY)
- After this initial login, you will be prompted to immediately change your password

Once you have successfully logged onto the Member portal, select the [Start Here] button located in the top left corner. You will have instant access to the following information:

- 1. Employee Claims** – you will be able to view the status of your claims, see payment details, as well as print Explanation of Benefit(s).
- 2. Employee File View** – you will be able to view your coverage information, as well the dependents that are part of this policy. This section will also allow you to verify the accuracy of the information.
- 3. Online Documents** – you have the ability to download a copy of your policy, print claim forms and have access to any other available references.

Online access is available to you 24/7, 365 days a year.

If you have any questions regarding your access, or require additional information, please contact us at +1 242 328 0935.

SECTIONS A, B, C, D, E, AND F ARE TO BE COMPLETED BY INSURED (EMPLOYEE).

A. INSURANCE INFORMATION

Group Name:

Group Number: Policy ID number:

B. EMPLOYEE INFORMATION

Employee's Name (Last, First, MI):

Date of Birth: NIB No:

Address: (No., Street, Island, Country):

Telephone No (including area code):

C. PATIENT INFORMATION

Patient Details (if different than Section B)

Patient's Name (Last, First, MI):

Date of Birth:

Address: (No., Street, Island, Country): Same as Section B

Telephone No (including area code):

Patient Sex: Male Female Patient's Relationship to Insured: Spouse Child Other

Is the Dependent a full-time student? Yes No

D. COORDINATION OF BENEFITS

Is the patient covered by another health plan? Yes No

If YES, please provide Insurance Company Name and Address

Name of Insured:

Group Name:

Group Number:

Policy ID number:

Effective Date of Coverage:

Is the Patient the: Insured Dependant

Is this claim work related? Yes No

Is this claim related to an accident? Yes No

Date of Incident:

Please provide a brief description of how the injury or accident occurred.

An incident/ accident report describing the nature and cause of the injury must accompany the claim form. In addition, if the accident is a result of a Motor Vehicle Accident, you must also include a Police Report. Failing to do so could delay the processing of your claim.

E. ASSIGNMENT OF BENEFITS

ASSIGNMENT: Please pay the balance due directly to the Provider at the address indicated in Section H

Yes No

If NO, please indicate your preferred method of payment. Select only one option.

1. Cheque - Indicate preferred currency

Based on Policy Currency (Bahamian or U.S. Dollars)

Issue in U.S. dollars; please ensure your bank will accept U.S. currency

NOTE: The cost of a U.S. bank draft is the responsibility of the Insured and will be deducted from the payable amount

2. Wire Transfer - You must fill out the International Wire Transfer Request form.

This can be found on the Member Portal at <https://services.hi-techhealth.com/bah/pages/signon.shtml> in the Online Document Section.

NOTE: The cost of the wire transfer is the responsibility of the Insured and will be deducted from the payable amount

ASSIGNMENT OF BENEFITS TO PROVIDER OF SERVICES I hereby authorize payment directly to the undersigned Provider of Services, if any, otherwise payable to me for services rendered as described below but not to exceed the reasonable customary charge for those services.

Signature of Insured Person (Parent or Guardian if claim is for a minor):

Date:

F. AUTHORIZATION TO RELEASE INFORMATION - CLAIM CANNOT BE PROCESSED WITHOUT THE INSURED'S SIGNATURE

AUTHORIZATION I certify that the information furnished by me in support of this claim is true and correct. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, pharmacist, educational institution or other person to release any information requested with respect to this claim. A photostatic copy or other reproduction of this release will be as valid as the original.

Signature of Insured Person (Parent or Guardian if claim is for a minor):

Date:

SECTIONS G AND H ARE TO BE COMPLETED BY PROVIDER OF SERVICES.

G. SUMMARY OF SERVICES PROVIDED

Date of CURRENT ILLNESS (first symptom) or INJURY (accident):

If Patient has had same or similar illness, please provide DATES:

1. 2. 3.

Diagnosis:

Service Category	Date of Service (MM/DD/YYYY)	Place of Service	Procedure Code	Description	Diagnosis Code	Unit	Charges
Eye Examination							
Single Vision Lenses							
Bifocal Lenses							
Trifocal Lenses							
Frames							
Contact Lenses							
Contacts (Medical)							
Other							
Other							
Patient Account Number: <input type="text"/>						Total Charges	
Physician/ Provider ID Number: <input type="text"/>						Amount paid	
						Balance Due	

H. PROVIDER INFORMATION AND AUTHORIZATION

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

Examiner/ Dispenser

Name of Provider:	<input type="text"/>	Provide official stamp (if available)
Address of Provider (No., Street):	<input type="text"/>	
City, Island, Country:	<input type="text"/>	
Telephone (include area code):	<input type="text"/>	
Fax (include area code):	<input type="text"/>	
Signature:	<input type="text"/>	
Date:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

I. DISCLAIMER

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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Generali Worldwide is a trading name of Utmost Worldwide Limited

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Regulated in Guernsey as a licensed insurer by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002 (as amended).
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