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 ___/___/_____	**4.** PATIENT'S SEX M_____ F_____
5. INSURED'S NAME (Last Name, First Name, Middle Initial)		
6. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include area code)	**7.** PATIENT'S RELATIONSHIP TO INSURED **9.** PATIENT'S STATUS Single _____ Married _____ Other _____ Employed _____ Full-time Student _____ Part-time Student _____	**8.** INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include area code)
10. PATIENT'S CONDITION RELATED TO **a)** EMPLOYMENT? (Current or Previous) _____YES _____NO **b)** AUTO ACCIDENT? _____YES _____NO PLACE (state) _____ **c)** OTHER ACCIDENT? _____YES _____NO	**11.** 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	
12. 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 ___/___/_____	**13.** INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned Physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) ___/___/_____	**15.** IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE ___/___/_____	
16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE _____	**17.** OUTSIDE LABS? $CHARGES (Indicate Currency) _____YES _____NO	
18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3,4,5 OR 6 TO ITEM 19B BY LINE) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		

19. 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					

20. FEDERAL TAX ID NUMBER	**21.** PATIENT'S ACCOUNT NO.	**22.** ACCEPT ASSIGNMENT?	**23.** TOTAL CHARGE	**24.** AMOUNT PAID	**25.** BALANCE DUE
_____SSN _____EIN		___YES ___NO			

26. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	**27.** NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	**28.** SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED_____ DATE ___ / ___ /_____		PIN# GRP#

Office: Generali Worldwide, Suite 14, Grand Pavilion Commercial Centre, 802 West Bay Road, Grand Cayman, KY1-1003
Mailing address: Generali Worldwide, PO Box 10281, Grand Cayman, KY1-1003 Cayman Islands.
Regulated in the Cayman Islands as a licensed insurer by the Cayman Islands Monetary Authority.
Incorporated in Guernsey under Company Registration No. 27151.
Tel. +1 345 940 2000 Fax +1 345 943 7288 Email caymanservicing@generali-healthcare.com
generali-healthcare.com

GW (UW) HC Cay GHI Med Dent Vis CF FINAL 02121