REIMBURSEMENT CLAIM FORM

REIMBURSEMENT GUIDELINES

IMPORTANT NOTICES

- All claims must be submitted within 180 days of the date of service.
- Submit completed forms via email at bhclaimsubmission@familyguardian.com or via e-services where applicable.
- To avoid delay in satisfying your annual deductible submit your service receipts immediately.
- Cash receipts are required as proof of payment.

SUPPORTING DOCUMENTATION REQUIRED

FOR PHARMACY CLAIMS

- Payment Receipt
- Prescription Script

FOR MEDICAL/VISION CLAIMS

- Payment Receipt

FOR TRAVEL/LODGING CLAIMS

- Air Travel Itinerary indicating cost of ticket
- Boarding Passes
- Lodging Invoice*
- Rental Vehicle Invoice*

***Only applicable for:**
- Hospital admission
- Overseas outpatient chemotherapy radiation

P.O. Box SS-19079 Nassau, Bahamas

Telephone: (242) 396-1311 | Website: www.bahamahealth.com

BahamaHealth is a Division of Family Guardian Insurance

Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

REIMBURSEMENT CLAIM FORM

SECTION 1: TO BE COMPLETED BY THE INSURED

Name of Policyholder:

Group Number: | Member ID Number:

Group Name:

Patient Name:

Patient Date of Birth: | Patient Gender ☐ Male ☐ Female

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Phone: | Email:

Is the patient covered under another Health Insurance policy? ☐ Yes ☐ No

If yes, state – Name of Insurer: Policy Number:

Is this claim related to: Patient's Employment? ☐ Yes ☐ No Accident? ☐ Yes ☐ No

SECTION 2: TO BE COMPLETED BY THE SERVICE PROVIDER

Not required if claiming for prescription drugs or travel reimbursement.

Patient Diagnosis/ Nature of Illness/ Injury:

Date of First Symptom of Current Illness, Injury, or Pregnancy (LMP):

Date of First Consult:

Name of Referring Physician:

Name of Service Provider/Facility:

Address of Service Facility:

TIN#: | Phone:

Email Address:

Was laboratory testing performed out of your office? ☐ Yes ☐ No

If applicable, please indicate all hospitalization dates related to service rendered.

Admission Date: | Discharge Date:

Admission Date: | Discharge Date:

DATES OF SERVICE [MM/DD/YYYY]		PLACE OF SERVICE*	PROCEDURE CODE	DIAGNOSIS CODE	UNITS/ DAYS	CHARGES (VAT EXCLUSIVE)
FROM	TO					

***PLACE OF SERVICE CODES**

11 Physician's Office
12 Patient's Home
21 Inpatient Hospital
22 Outpatient Hospital
81 Independent Laboratory

VAT CHARGES	
TOTAL CHARGES	
PATIENT PAYMENT AMOUNT	
BALANCE	

DECLARATION OF SERVICE PROVIDER

I certify that the statements on this form are true and complete to the best of my knowledge.

Provider Name: _____

Signature: _____ Date: _____

RELEASE OF INFORMATION

I hereby certify that the foregoing answers are true and correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim.

Claimant Name: _____

Signature: _____ Date: _____