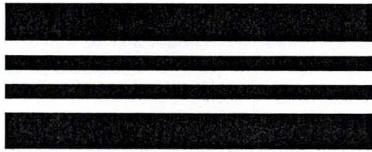


PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



A DIVISION OF FAMILY GUARDIAN

CARRIER

HEALTH INSURANCE CLAIM FORM

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	

PATIENT AND INSURED INFORMATION

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) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER		24. A B C D E F G H I J K DATE(S) OF SERVICE To Place of Type of PROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS \$ CHARGES DAYS OR EPSPDT EMG COB RESERVED FOR LOCAL USE From To Service Service (Explain Unusual Circumstances) CODE MM DD YY MM DD YY CPT/HCPCS MODIFIER	

PHYSICIAN OR SUPPLIER INFORMATION

A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSPDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
SIGNED _____				DATE _____				PIN# _____			
								GRP# _____			

**HOW TO COMPLETE THE BAHAMAHEALTH CLAIM FORM**

***Most services require pre-certification or verification of benefits,  
Therefore please call telephone number 396-1303.***

**Complete all areas on the claim form for timely reimbursement. Failure to do so may delay the processing of this claim.**

***Provider Claims:***

*Items 1-13 should be completed on the BahamaHealth patient.  
Items 14-33 should be completed by the physician or provider of service.*

***\*\*\*Claims must be submitted within six months of the date of service\*\*\****

***\*\*\*Amendments should be initialed, Liquid paper will not be accepted\*\*\****

***Original receipts must be submitted. Copies will be accepted only if BahamaHealth is the secondary payer. A copy of a worksheet from the primary payer must accompany this form if BahamaHealth is the secondary payer.***

***With respect to accidents, please attach to the claim form, a written account of circumstances surrounding the accident.***

***Receipts for co-payments should not be submitted for reimbursement.***

***Please submit claims to:***

***BAHAMAHEALTH  
Claims Department  
2<sup>nd</sup> Floor, Family Guardian Financial Centre  
Corner of Church and East Bay Streets  
P.O. Box SS-19079  
Nassau Bahamas***

**Claims may be emailed to [bhclaimssubmission@familyguardian.com](mailto:bhclaimssubmission@familyguardian.com)  
Originals must be submitted thereafter.**