



Insurance Corporation of Barbados Limited

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HEALTH INSURANCE CLAIM FORM

NOTE: CLAIMS MUST BE SUBMITTED WITHIN YOUR POLICY FILING PERIOD TO BE ELIGIBLE FOR REIMBURSEMENT

PLEASE USE BLOCK CAPITALS

1. INSURED'S NAME (LAST, FIRST, INITIAL)		8. PATIENT'S NAME (LAST, FIRST, INITIAL)	
2(a). INSURED'S ADDRESS		9. PATIENT'S ADDRESS	
(b). TELEPHONE (INCLUDE AREA CODE)		10 (a). Patient's Date of Birth	
(c). Email Address		10 (b). GENDER	
3(a). INSURED'S DATE OF BIRTH		D: <input type="checkbox"/> M: <input type="checkbox"/> Y: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	
D: <input type="checkbox"/> M: <input type="checkbox"/> Y: <input type="checkbox"/>		11. Patient's Relationship to Insured	
3(b). GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	
4(a). INSURED'S POLICY NO.		12. PATIENT'S STATUS	
4(b). INSURED'S CERTIFICATE NO.		Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Employed <input type="checkbox"/>	
5. EMPLOYER'S/GROUP'S NAME		Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/> Retired <input type="checkbox"/>	
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN?		13. IS PATIENT CONDITION RELATED TO	
YES <input type="checkbox"/> NO <input type="checkbox"/> (yes, complete 7a - 7c)		A. EMPLOYMENT (CURRENT OR PREVIOUS)	
7(a). OTHER INSURED'S NAME (LAST, FIRST, INITIAL)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
(b). OTHER INSURED POLICY OR GROUP NUMBER		B. AUTO ACCIDENT	
(C). OTHER INSURED'S DATE OF BIRTH		YES <input type="checkbox"/> NO <input type="checkbox"/>	
D: <input type="checkbox"/> M: <input type="checkbox"/> Y: <input type="checkbox"/>		C. OTHER ACCIDENTS	
15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
I authorize payment of medical benefits to:		Kindly describe on separate sheet	
Hospital		14. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.	
Doctor		SIGNED..... DATE.....	
Surgeon		INSURED SPOUSE (IF PATIENT)	
SIGNED..... DATE.....			

PATIENT AND INSURED INFORMATION

(TO BE COMPLETED BY PLAN ADMINISTRATOR)

Verified by Policyholder/Plan Administrator Effective Date of Insured's coverage _____ Effective date of Dependent's coverage _____

SIGNED

COMPANY STAMP

DATE

GUIDELINES

Our goal is to process your claim within the turnaround time we have indicated to you. In order for us to fulfill this goal, you can help us by ensuring that the following guidelines are followed:

THE CLAIM FORM

- > Prepare a separate claim form for each family member.
- > Complete ALL of the information requested with EACH claim submission.
- > If you prefer that benefits be paid to the provider of services, be sure to complete the authorization for assignment of benefits section of the claim form (Section #15) and attach invoices.

THE PROVIDER BILLING OR REPORT

Each bill/receipt should carry:

- > The name, address, person or organization providing the service.
- > The name of the patient receiving the service.
- > The date of each service (a range of services cannot be accepted)
- > The charge for each individual service, employer's section.
- > A description of each service.

Have you?

- Fully completed and signed the claim form.
- Attached all relating itemized bills/receipts.
- Kept copies of documentation for your records.
- Had your Plan Administrator complete the employer's section.

On each bill/receipt, please delete any charges that were included on a previous claim. Personal itemizations, cash register receipts, credit card receipts and cancelled cheques are not acceptable.

16. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			17. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO											
D	M	Y	D	M	Y	D	M	Y	D	M	Y						
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO:											
						D	M	Y	D	M	Y						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE						22. OUTSIDE LAB? CHARGES (\$)											
1. 2.						YES <input type="checkbox"/> NO <input type="checkbox"/>											
23. A		B		C		D		E		F		G					
DATE OF SERVICE			PLACE OF SERVICE		PROCEDURES, SERVICES OR SUPPLIES CODE			DIAGNOSIS		CHARGES		UNITS FOR		FURTHER SERVICES			
D	M	Y	OFF/HOSP/HOME		(Explain Unusual Circumstances)			CODE (1,2)		\$		DAYS		RECOMMENDED			
24. ACCEPT ASSIGNMENT						25. TOTAL PAID		26. AMOUNT PAID		27. BALANCE DUE							
ADDITIONAL INFORMATION CAN BE NOTED ON SEPARATE SHEET						\$		\$		\$							
						YES <input type="checkbox"/> NO <input type="checkbox"/>											
28. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS						29. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						30. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS OR PHONE NUMBER					
Signed _____ Date _____																	
RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED																	

PHYSICIAN OR SUPPLIER INFORMATION

Accidental Injury - Statements must contain details as to when, where and the manner in which the injury occurred as well as the name and address of the party at fault where applicable.

Prescription only drugs - Bills/Receipts must include the prescription number, the name of the drug and the name of the physician prescribing the medication. (Please note that the cost of **each** drug must be indicated and receipts must carry the name/ stamp of the pharmacy).

Private Duty Nursing - Bills/Receipts must include shift worked, the charge per hour, the number of hours worked, the nurse's professional status, the family relationship to the patient if any. A statement from the attending physician explaining the necessity of this service and authorization of the service should accompany the claim.

Prosthetic appliances and the rental or purchase of durable equipment - A statement from the attending physician should accompany the claim. The statement should explain the medical necessity of the equipment and the physician's authorization for it.

For patients covered by another insurance carrier - If the patient is claiming benefits for any charges that are eligible for benefits under another health insurance policy, the explanation of benefits worksheet furnished by the other company pertaining to these expenses must be included with the itemized bills. A CLEAR copy of the other carrier's explanation of benefits worksheet is acceptable in place of the original document.