BAF FINANCIAL INSURANCE (BAHAMAS) LIMITED

GROUP INSURANCE HEALTH CLAIM FORM

To be completed by the Treating Physician
(PLEASE USE BLOCK LETTERS)

BAF TIN #: 100239418

1. Patient's Name (first, middle initial, last)	2. Patient's Birth date **MM/DD/YY**	3. Insured's Name (first, middle initial, last)
4. Patient's full address & phone number	5. patient's sex: Male Female	6. Insured's BAF Group/ID number
7. Relationship to insured self spouse child other	8. Is dependent a full-time student? Yes No If YES name and address of school	9. Does patient have other health insurance? Yes No If YES, give name of Insurance Company, address, policy and name of Insured.
10. Was condition related to: A. Patient's employment B. Auto Accident Pregnancy ☐ Substance abuse ☐ Other		11. Please provide date and brief details.

12. **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 photocopy or other reproduction of this release will be as valid as the original.

SIGNATURE OF THE PATIENT: _____ **DATE:** _____

13. **ASSIGNMENT OF BENEFITS TO PHYSICIAN** I hereby authorize payment directly to the undersigned **Medical Services Provider**.

SIGNATURE OF INSURED: **DATE:**

PHYSICIAN OR SUPPLIER

14. Date first symptom injury or pregnancy (LMP)	15. Date patient first consulted you for this condition:	16. Has patient ever had same or similar symptoms prior to this visit?
17. If Patient was unable to work due to this illness give date(s):	18. If patient was hospitalized for this illness give date(s):	

19. Name and address of referring physician	20. Name and address of facility where services rendered

21. Please list any other insurance companies with which you have filed this claim.

Diagnosis or nature of illness or injury.

1. _____ 2. _____ 3. _____ 4. _____

Date of Service **MM/DD/YYYY**	Place of Service	Procedure Code	Description of Procedure Service	Diagnosis Code	Charges

I CERTIFY THAT THE INFORMATION FURNISHED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Physician or Supplies, Date (DD/MM/YY)	Name, Address of Physician or supplier	Total Charge	Paid	Due
Patient's Account #		Your ID#	Accept Assignment? Yes No	