CG | ATLANTIC MEDICAL & LIFE

VISION/EYE CARE CLAIM FORM

CLAIM NO. _____

Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 180 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.
Please submit completed form via Email to BS_claims_admin@cgcoralisle.com or via Fax to 242 326 8189.

PART 1 To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured _____

Group Policy No. _____ Certificate/Employee No. _____

Name of Employer _____ Transit No. _____

Full Name of Patient _____

Patient's Mailing Address _____ Tel. No. _____

Patient's Date of Birth (DD/MM/YY) _____ Patient's Gender ☐ Male ☐ Female

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If the Patient has any other Health Insurance coverage, provide name of policy holder and number _____

Was sickness/injury related to ☐ Patient's employment ☐ Traffic Accident ☐ Pregnancy ☐ Other (give details below)

_____

DECLARATION: I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions to furnish full information, including full copies of records, regarding this claim to CG Atlantic Medical & Life Insurance Ltd.

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS (sign only if requesting direct payment to hospital or doctor): I hereby authorise payment directly to the hospital, and physician where applicable, named on the attached claim form, other than Insurance Benefits under Policy ....., otherwise payable to me but not to exceed the regular charges for the treatment and/or services supplied. I understand that I am financially responsible for the charges not covered by the Policy.

Patient's or Authorised Person's Signature _____ Date _____

PART 2 To be completed by the ATTENDING PHYSICIAN

A separate claim form or itemized account should be submitted by each attending physician.

Provider Name: _____ Contact No. (_____) _____

Mailing Address _____

Date of illness (first symptom), injury (accident) or pregnancy (last monthly period) (DD/MM/YY) _____

Date patient first consulted you for this condition (DD/MM/YY) _____

Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Name of referring physician or other source _____

Hospitalisation dates related to current services (if applicable) Admitted (DD/MM/YY) _____ Discharged (DD/MM/YY) _____

Name and address of facility where services rendered (if other than home or office) _____

_____

Was laboratory work performed outside your office? ☐ Yes ☐ No

Was the following operation(s) to correct a condition detrimental to the patient's health? ☐ Yes ☐ No

CG | ATLANTIC MEDICAL & LIFE

VISION/EYE CARE CLAIM FORM

Health Insurance

PART 3 VISION PROCEDURE/DIAGNOSIS CODES & DECLARATION

✓	Code	Procedure/CPT Description	Fee
	92004	Examination - New Patient	
	92014	Examination - Established Patient	
	92081	Visual Field report	
	V2020	Frames	
	V2100	Single Vision Lenses	
	V2200	Bifocal Lenses	
	V2300	Trifocal Lenses	
	V2500	Contact Lenses	
	V2740	Tint	
	V2750	Anti-Reflective Coating	
	V2760	Scratch Resistent	
	V2781	Progressive Lenses	

✓	Code	ICD10 Diagnosis Description	Fee
	H52	Disorders of refraction and accommodation	
	H520	Hypermetropia	
	H5203	Hypermetropia, bilateral	
	H521	Myopia	
	H5213	Myopia, bilateral	
	H52221	Regular astigmatism, right eye	
	H52222	Regular astigmatism, left eye	
	H52223	Regular astigmatism, bilateral	
	H524	Presbyopia	
	H5302	Refractive amblyopia	
	Z010	Encounter for examination of eyes and vision	
	Z0100	Encounter for eye exam w/o abnormal findings	
	Z0101	Encounter for eye exam w abnormal findings	

Diagnosis (if not defined above):	Total Charges	$ 0.00
	VAT Tax (if applicable)	
	Payment Made	

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

Signature _____ Date _____

CG Atlantic Medical & Life Insurance Ltd.
Atlantic House, 2nd Terrace & Collins Avenue | PO Box SS-5915, Nassau, Bahamas | Tel 242 326 8191 | Fax 242 326 8189
Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442
www.CGCoralisle.com

Rev. 03-22