Clear Form

Sagicor

DENTAL CARE CLAIM FORM

ATTIC

NOTE: CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF BEING INCURRED TO BE ELIGIBLE FOR REIMBURSEMENT

PATIENT/INSURED INFORMATION

1. Insured's Name (Surname, First Name, Middle Initial)	Date of Birth D M Y	2. Plan Number Certificate No. Company/Plan
3. Insured's Address and Telephone Number		4. Patient's Address (if different)
5. Patient's Name (Surname, First Name, Middle Initial)	Date of Birth D M Y	Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____
6. Is Patient Covered by Another Dental Plan ☐ Yes ☐ No	Dental Plan Name	Plan Number Name of Carrier

I hereby certify that the foregoing answers are true and correct. I authorize release of any information relating to this claim to Sagicor Life Inc. *(Please indicate applicable company.)*

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or with intent to mislead, conceals information concerning any fact material thereto, commits a fraudulent act and is liable to prosecution.

_____ Signature (Insured Person)

_____ Signature(Patient, or Parent, if Minor)

_____ Date

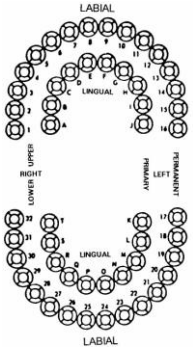
I hereby authorize payment directly to the Dentist/Provider named below, of the Group Insurance benefits otherwise payable to me.

_____ Signature (Insured Person)

_____ Date

DENTIST OR SUPPLIER

Dentist's Name	If crown, was tooth badly broken down? ☐ Yes ☐ No	If "Yes", enter brief description and dates	
Address	Is treatment result of occupational illness or injury? ☐ Yes ☐ No		
	Is treatment result of auto accident? other accident? ☐ Yes ☐ No		
Tel. No.	Are any services covered by another plan? ☐ Yes ☐ No		
First Visit Date D M Y	Place of Treatment Office ☐ Hospital ☐ Other ☐	X-rays or models enclosed? ☐ Yes ☐ No	How Many?
Is the treatment for orthodontics ☐ Yes ☐ No			
If prothesis is this initial placement? ☐ Yes ☐ No	If "Yes", give date of extractions of teeth being replaced.	If "No", give reason for replacement and date of prior placement.	



Indicate Missing Teeth with an "X"

Examination and Treatment Plan. List in order. Use charting system shown.

Tooth # or Letter	Surface	Description of Service (Including X-rays, Prophylaxis, materials used, Root canal (# of Canals), Etc)	Date Service Performed (d/m/y)	Fee	
Remarks for unusual services					

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

"I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED."

_____ Signature of Dentist

_____ Date

PLAN ADMINISTRATOR'S SECTION

Effective Date of Insured's Coverage _____

Effective Date of Dependent's Coverage_____

_____ Signature of Administrator

_____ Company Stamp

_____ Date

GUIDELINES

Our goal is to process your claim within the **10 day turnaround** time we have indicated to you. In order for us to fulfil 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.

THE PROVIDER BILLING OR RECEIPT

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.
- A description of each service.

On each bill, 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. **PLEASE NOTE THAT ORIGINAL RECEIPTS CANNOT BE RETURNED UNLESS ACCOMPANIED BY CLEAR COPIES.**

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 the 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 the 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 any other 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.

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.

Sagicor Life Inc
16 Queen's Park West, Port Of Spain, Trinidad and Tobago.
Tel: (868) 628-1636 Fax: (868) 628-163