CG | INSURANCE

VISION/EYE CARE CLAIM FORM

Claim No. _____

Premier Health

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.
Please submit completed form via Email to Medical_claims_BM@cgcoralisle.com or via Fax to 441 295 9036.

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

Full Name of Insured _____

Policy No. _____ Certificate No. _____

Name of Employer _____

Full Name of Patient _____

Patient's Mailing Address _____

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

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

If you have any other Health Insurance coverage, provide name of policy holder and policy 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 Coralisle Insurance (BVI) 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 form to be submitted by each physician)

Provider Name _____ Contact No. (_____) _____

Mailing Address _____

Date of illness (first symptom), injury (accident) or pregnancy (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 (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

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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
	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 _____

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Personal and Business Insurance, Health Insurance and Employee Benefits, Life Assurance

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