One Health Cayman

Medical Claim Form

SECTION A: ENROLLEE AND PATIENT INFORMATION

Patient's Identification Number

Patient's Date Of Birth

Group ID

Patient's Name (First, Last)

Patients Relation to Subscriber

Self | Spouse | Child | Other

Subscribers Name (First, Last)

Patient's Mailing Address

Condition Related To:

- Employment, Date
- Auto Accident, Date
- Other Emergency, Date
- Pregnancy, LMP
- Substance Abuse, Date
- Other, Date

Subscribers Mailing Address (if different than patient)

Patient's Phone No

Subscribers Phone No

Patient's Other Health Insurance *(If any)*

Patient's Authorization
I authorize One Health Cayman to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.

Signature Date

Payment Assignment
I authorize One Health Cayman to pay the proceeds of this claim to the undersigned Medical Services Provider.

Signature Date

SECTION B: MEDICAL SERVICE INFORMATION

Date of first symptom or LMP *(if pregnant)*

Provider Name and Address

Date you first treated patient for this illness

If patient had suffered same or similar illness before, give date(s)

Was outpatient diagnostic services ordered, or medication prescribed?

YES NO

If patient was unable to work due to this illness, give date(s)

If patient was hospitalised for this illness, give date(s)

Nature of accident, if applicable

DIAGNOSIS, ILLNESS OR INJURY		TREATMENT SERVICES			
Code	Description	Dates: To-From	Code	Description	Charge USD$

Patient Account Number

Accept Assignment? YES NO

Total Charge: USD$

Patient Paid Amt

Balance Outstanding: USD$

BANK DETAILS: If you would like to be reimbursed by EFT direct deposit, please provide your Cayman banking details.

Bank Name	Account Name	Account Number	Account Type	Account Currency

I certify that the information furnished above is true and correct to the best of my knowledge.

Name Date

Once complete, please email this form and itemized receipts to **claims@onehealth.ky**