CG | UNITED

HEALTH CLAIM FORM

Claim No. _____

Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.
Please submit completed form to Medical_Claims_BB@cgcoralisle.com.

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 other Health Insurance coverage, provide name and number of policy _____

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 Medical Insurance Company 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 attending physician)

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

DECLARATION OF PHYSICIAN OR SUPPLIER: I certify that the statements on this form are true and complete to the best of my knowledge.

Full Name _____ Telephone _____

Mailing Address _____

Signature _____ Date _____

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HEALTH CLAIM FORM

Patient Name _____ Date of Service _____

Place of Service: ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Doctor's Office ☐ Patient's Home ☐ Independent Laboratory

Diagnoses
1.
2.
3.
4.
5.
6.

Office visit	New	Est	Charge
Minimal		99211	
Problem focused	99201	99212	
Expanded problem focused	99202	99213	
Detailed	99203	99214	
Comprehensive	99204	99215	
Comprehensive (new patient)	99205		
Significant, separate service	-25	-25	
Well visit	**New**	**Est**	
< 1 y	99381	99391	
1-4 y	99382	99392	
5-11 y	99383	99393	
12-17 y	99384	99394	
18-39 y	99385	99395	
40-64 y	99386	99396	
65 y +	99387	99397	
Consultation/preop clearance			
Expanded problem focused		99242	
Detailed		99243	
Comprehensive/mod complexity		99244	
Comprehensive/high complexity		99245	
Physical Therapy	**Occurrence**		
Physical Therapy Evaluation		97001	
PhyTher 1 area Each 15 min		97110	
Radiology			
Mammogram		77067	
Echo Abdominal B Scan W/Image		76700	
Echo Pelvis B Scan w/Image		76856	
Radiation Exam Chest - Single View		71010	
Radiation Exam Chest 2 Views		71020	
Miscellaneous services			
Other services			

Office procedures		Charge
Anoscopy	46600	
Audiometry	92551	
Cerumen removal	69210	
Colposcopy	57452	
Colposcopy w/biopsy	57455	
ECG, w/interpretation	93000	
ECG, rhythm strip	93040	
Endometrial biopsy	58100	
Flexible sigmoidoscopy	45330	
Flexible sigmoidoscopy w/biopsy	45331	
Fracture care, cast/splint	29	
Site:		
Nebulizer	94640	
Nebulizer demo	94664	
Spirometry	94010	
Spirometry, pre and post	94060	
Tympanometry	92567	
Vasectomy	55250	
Skin procedures	**Units**	
Burn care, initial	16000	
Foreign body, skin, simple	10120	
Foreign body, skin, complex	10121	
I&D, abscess	10060	
I&D, hematoma/seroma	10140	
Laceration repair, simple	120	
Site: Size:		
Laceration repair, layered	120	
Site: Size:		
Lesion, biopsy, one	11100	
Lesion, biopsy, each add'l	11101	
Lesion, destruct., benign, 1-14	17110	
Lesion, destruct., premal., single	17000	
Lesion, destruct., premal., ea. add'l	17003	
Lesion, excision, benign	114	
Site: Size:		
Lesion, excision, malignant	116	
Site: Size:		
Lesion, paring/cutting, one	11055	
Lesion, paring/cutting, 2-4	11056	
Lesion, shave	113	
Site: Size:		
Nail removal, partial	11730	
Nail removal, w/matrix	11750	
Skin tag, 1-15	11200	
Medications	**Units**	
Ampicillin, up to 500mg	J0290	
B-12, up to 1,000 mcg	J3420	
Epinephrine, up to 1ml	J0170	
Kenalog, 10mg	J3301	
Lidocaine, 10mg	J2001	
Normal saline, 1000cc	J7030	
Phenergan, up to 50mg	J2550	
Progesterone, 150mg	J1055	
Rocephin, 250mg	J0696	
Testosterone, 200mg	J1080	
Tigan, up to 200 mg	J3250	
Toradol, 15mg	J1885	
Supplies		

Laboratory		Charge
Venipuncture	36415	
Blood glucose, monitoring device	82962	
Blood glucose, visual dipstick	82948	
CBC, w/ auto differential	85025	
CBC, w/o auto differential	85027	
Cholesterol	82465	
GLU; Quan	82947	
Hemoccult, guaiac	82270	
Hemoccult, immunoassay	82274	
Hemoglobin	85018	
HGB; Glycated AIC	83036	
Lipid panel	80061	
Liver panel	80076	
KOH prep (skin, hair, nails)	87220	
Metabolic panel, basic	80048	
Metabolic panel, comprehensive	80053	
Mononucleosis	86308	
Pap Smear/Cytopath Cervical/Vaginal Thin Prep	88143	
Pregnancy, blood	84703	
Pregnancy, urine	81025	
Prostate Specific Antigen	84153	
Renal panel	80069	
Sedimentation rate	85651	
Strep, rapid	86403	
Strep culture	87081	
Strep A	87880	
TB	86580	
Thyroid Stimulating Hormone	84443	
UA, complete, non-automated	81000	
UA, w/o micro, non-automated	81002	
UA, w/ micro, non-automated	81003	
Urine colony count	87086	
Urine culture, presumptive	87088	
Wet mount/KOH	87210	
Vaccines		
DT, <7 y	90702	
DTP	90701	
DtaP, <7 y	90700	
Flu, 6-35 months	90657	
Flu, 3 y +	90658	
Hep A, adult	90632	
Hep A, ped/adol, 2 dose	90633	
Hep B, adult	90746	
Hep B, ped/adol 3 dose	90744	
Hep B-Hib	90748	
Hib, 4 dose	90645	
HPV	90649	
IPV	90713	
Immunizations & Injections	**Units**	
Allergen, one		95115
Allergen, multiple		95117
Imm admin, one		90471
Imm admin, each add'l		90472
Imm admin, intranasal, one		90473
Imm admin, intranasal, each add'l		90474
Injection, joint, small		20600
Injection, joint, intermediate		20605
Injection, joint, major		20610
Injection, ther/proph/diag		90772
Injection, trigger point		20552

Today's charges: _____ Today's payment: _____ Balance due: _____

CG United Insurance Ltd. PO Box 1215, Lower Broad Street, Bridgetown BB11000, Barbados
Tel 246 538 4444 | **www.CGUnited.com**

Underwritten and administered by Coralisle Medical Insurance Company Ltd.
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Members of Coralisle Group Ltd.

Rev. 07-24