# AUC STUDENTS' HEALTH CLAIM FORM

Remember to attach original receipts/itemized bills
Notification and proof of claim must be submitted within 90 days

☐ HEALTH ☐ VISION ☐ DENTAL

| **1. TO BE COMPLETED BY STUDENT/INSURED** | | For further information, please contact our claim specialists, Angela Colli and Melincia Gario, at 542-2739 ext 289 or 285. |
|---|---|---|
| Policy NO.: **GLHI200/10**<br>Card NO.: | Policy Holder:<br>**American University of the Caribbean – St. Maarten** | |
| Student's/Insured's name: | Patient's Name: | Patient's Date of Birth: |
| Student's e-mail address: | | |
| Address: / Telephone No.: | Is patient's condition related to: a. Employment ☐ Yes ☐ No<br>b. Auto accident ☐ Yes ☐ No c. Other Accident ☐ Yes ☐ No<br>If yes, Give Details | |
| Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? ☐ Yes ☐ No<br>If Yes, give (a) Name of Insurance Company _____<br>(b) Name of Group or Company insured under _____ | | |

I hereby authorize and direct you to pay to _____ all benefits accruing to me as a result of this claim to the extent of bills submitted.

Authorization: I hereby authorize the doctor to release any information acquired in the course of my examination or treatment to NAGICO Insurances.

Insured's Signature _____ Patient's Signature _____ Date _____

| **2. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER** | |
|---|---|
| Patient's Name: | |
| Diagnosis or nature of illness or injury (ICD CODE)<br>1. 3.<br>2. 4. | Name & Address of Doctor/Health Provider:<br>Give name of referring physician |
| Is condition due to Pregnancy? ☐ Yes ☐ No If Yes, give approximate date of last monthly period: | |
| **3. TO BE COMPLETED BY DOCTOR- MEDICAL/SURGICAL TREATMENT** | |
| Date of first symptoms:<br>Date of first consultation for this condition: | Has patient been previously treated for this condition? ☐ Yes ☐ No<br>If Yes, Give date: |

| A<br>Date (DD/MM/YY) | B<br>Place of Service (Office/Home/Hosp.) | C<br>Procedures, Services or supplies (Explain unusual circumstances) | D<br>Diagnosis 1,2,3,4 | E<br>Charges $ | E<br>Charges ¢ |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| Further services recommended | Surgical procedure | $ | ¢ |
|---|---|---|---|
| | Date of Operation: | | |
| | Type of Operation: | | |
| | Name of Surgeon: | | |
| | Name of Assistant Surgeon: | | |
| | Name of Anesthetist: | | |
| | **TOTAL** | | |

I hereby certify that the above services as indicated by date have been completed.

Stamp _____ Signature of Doctor _____ Date _____

**RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED UNLESS ASSIGNED.**

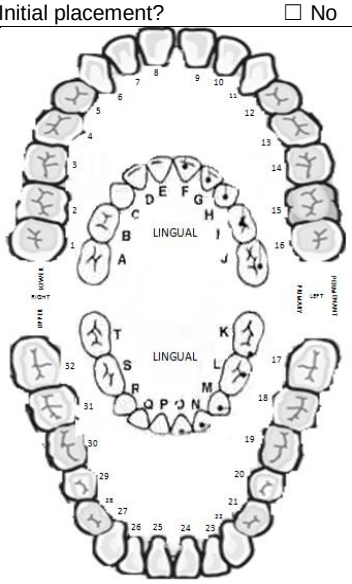
NAGICO INSURANCES

| **4. TO BE COMPLETED BY HOSPITAL** | | Charges | |
|---|---|---|---|
| NO. of days confined: | ☐ Private ☐ Semi-private ☐ Ward | $ | ¢ |
| Daily hospital charge for patient: ($ ) | From: To: | | |
| Operation or delivery room (state type of operation): | | | |
| Hospital services: | | | |
| Name of admitting Doctor: | | | |

| **5. TO BE COMPLETED BY LABORATORY/X-RAY DEPARTMENT** | | |
|---|---|---|
| Date and type(s) of test(s) | $ | ¢ |
| | | |
| | | |

**6. TO BE COMPLETED BY DENTIST**

| Dentist: | If Yes, enter brief description and dates below | |
|---|---|---|
| | If crown, was tooth badly broken down? ☐ Yes ☐ No | |
| Address: | Is treatment result of occupational illness or injury? ☐ Yes ☐ No | |
| Telephone No.: | Is treatment result of auto accident? Other Accident? ☐ Yes ☐ No | |
| First visit date (dd/mm/yy) | Place of treatment: ☐ Hospital ☐ Office ☐ Other | X-rays or models enclosed? ☐ Yes ☐ No — How many? |
| If prosthesis 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

| Date of service (dd/mm/yy) | Tooth # Or Letter | Surface | Description of service | Charges $ | Charges ¢ |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| ☐ Predetermination ☐ Actual | | | **TOTAL** | | |

**7. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST**

| Diagnosis | Date of service (dd/mm/yy) | Description of service | Charges $ | Charges ¢ |
|---|---|---|---|---|
| | | (A) Examination | | |
| | | (B) Frames | | |
| | | (C) Lenses (please specify type below) | | |
| | | (D) Tinting | | |

☐ Single ☐ Bi-focal ☐ Lenticular ☐ Contact Lenses

(a) If Contact Lenses, were they prescribed severe corneal astigmatism, corneal scarring, keratoconus or aphakia? ☐ Yes ☐ No
Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? ☐ Yes ☐ No
Can visual acuity be improved by up to at least the 20/70 level by contact lenses? ☐ Yes ☐ No
(b) Are these prescription sun glasses? ☐ Yes ☐ No
Replacement of LOST or DAMAGED GLASSES? ☐ Yes ☐ No

**TOTAL EXPENSES**

**8. THIS FORM MUST BE SIGNED BY DENTIST/OPTOMOTRIST/AUTHORISED PERSON**

I hereby certify that the above services as indicated by date have been completed.

_____ Stamp

_____ Signature of provider

_____ Date