HEALTH INSURANCE CLAIM FORM

APPROVED BY THE BERMUDA HEALTH COUNCIL 10/09

PLEASE PRINT OR TYPE IN UPPERCASE LETTERS

1. NAME OF INSURANCE COMPANY

ARGUS ☐   BF&M ☐   COLONIAL ☐   FM ☐   GEHI ☐   HIP ☐   OTHER: _____ ☐

1a. INSURED'S CERTIFICATE NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE   SEX
MM   DD   YYYY
M ☐   F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐   Spouse ☐   Child ☐   Other ☐

7. INSURED'S ADDRESS (No., Street)

PARISH

8. PATIENT STATUS
Single ☐   Married ☐   Other ☐
Employed ☐   Full-Time Student ☐   Part-Time Student ☐

PARISH

POSTAL CODE   **TELEPHONE (Include Area Code)**
(   )

POSTAL CODE   **TELEPHONE (Include Area Code)**
(   )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. **EMPLOYMENT? (Current or Previous)**
YES ☐   NO ☐

11. INSURED'S POLICY GROUP NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. **AUTO ACCIDENT?**
YES ☐   NO ☐

a. INSURED'S DATE OF BIRTH   SEX
MM   DD   YYYY
M ☐   F ☐

b. OTHER INSURED'S DATE OF BIRTH   SEX
MM   DD   YYYY
M ☐   F ☐

c. **OTHER ACCIDENT?**
YES ☐   NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

SIGNED _____   DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT:
MM   DD   YYYY
◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE   MM   DD   YYYY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM   DD   YYYY   MM   DD   YYYY
FROM _____   TO _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MM   DD   YYYY   MM   DD   YYYY
FROM _____   TO _____

19. ADDRESS

20. HOSPITAL LAB?   **$ CHARGES**
YES ☐   NO ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Related Items 1, 2, 3 or 4 to Item 23E by Line)

1. _____ . _____   3. _____ . _____
2. _____ . _____   4. _____ . _____

22. PRIOR AUTHORIZATION NUMBER

23. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		D. DIAGNOSIS POINTER	E. $ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. RENDERING PROVIDER ID. #
From			To				CPT/HCPCS	MODIFIER					
MM	DD	YYYY	MM	DD	YYYY								
1													
2													
3													
4													
5													
6													

24. PATIENT'S ACCOUNT NO.

25. ACCEPT ASSIGNMENT?
YES ☐   NO ☐

26. TOTAL CHARGE
$

27. AMOUNT PAID
$

28. BALANCE DUE
$

29. SIGNATURE OF PROVIDER (I certify that any supporting documents apply to this bill and are made a part thereof.)

SIGNED _____   DATE _____

30. NAME AND ADDRESS OF OFFICE SUBMITTING CLAIM

31. PROVIDER TYPE
Physician ☐   Optometrist ☐   Psychologist ☐
Dentist ☐   Allied Health ☐   Other: _____ ☐

Instructions for completing the Health Insurance Claim Form (HICF)

The following instructions are for completion of the Health Insurance Claim Form (HICF) in Bermuda. The HICF is completed by any healthcare provider submitting a medical claim on behalf of insured patients.

Patient and Insured (policy holder) information

This section of the HICF form contains information about the patient and insured. When completing the HICF form, data for the date fields should be entered using the 8-digit (MM DD YYYY) format.

Block 1 – indicate the name of the health insurance company or scheme the patient is insured with by checking the appropriate box. Usually, only one box is checked except when the claim involves dual coverage, in which case more than one box is checked.

Block 1a – Enter the insured's health insurance certificate number exactly as it appears on his or her ID card.

Block 2 – Enter the patient's last name, first name, and middle initial (if any). Do not use shortened names or nicknames. (Remember to use uppercase letters and no punctuation.)

Block 3 – Enter the patient's 8-digit birth date, using the MM DD YYYY format, and check the appropriate box under "sex." It is important to use this exact formatting style (the 4-digit year) for a birth date so that it is clear when the patient was born.

Block 4 – Enter the insured name here exactly as it is listed on the insurance card. If the patient and the policy holder are the same, enter the name accordingly.

Block 5 – Enter the patient's mailing address and telephone number as the form indicates. Do not use punctuation or separate the telephone number groups with dashes.

Block 6 – Check the applicable box for the patient's relationship to the insured when Block 4 is completed.

Block 7 – Enter the insured's address and telephone number. If the address is the same as the patient's, enter the address. Usually, this item is completed only when Blocks 4 and 11 are completed.

Block 8 – Check the appropriate box for the patient's marital status and whether employed or a student.

Blocks 9-9d – Enter the requested information as it pertains to dual coverage. This would only occur in very unique circumstances; in which case providers should seek clarification directly from the insurance company/scheme involved.

Blocks 10a-10c – This is a crucial area of the form. You must check "yes" or "no" to indicate whether the services or procedures listed in Block 23 are the result of an accident or illness resulting from employment, an auto accident or other accident. An item checked "yes" indicates that there may be another insurance carrier that is primary, such as workman's compensation or an auto insurance carrier.

Block 11a- d – Enter the requested information as pertains to the insured.

Block 11a – Enter the insured's 8-digit birth date and sex, *if different from Block 3*.

Block 11b – If this is an employer-sponsored group insurance, enter the employer's name.

Block 11c – For most claims, this item is left blank. If you have questions, check with the insurer/insurance scheme.

Block 11d – For most claims, this item is left blank. Check "yes", or "no," whichever is applicable. If marked "YES," complete Blocks 9 and 9a-d.

Block 12 – The patient's or authorized individual's signature indicates there is an authorization on file for the release of any medical or other information necessary to process or adjudicate the claim. The words "signature on file" can be inserted in place of the patient's or authorized individual's signature.

Block 13 - A signature here tells the insurance carrier that the insured authorizes them to **assign benefits** to the provider delivering the service (send reimbursement check directly to the healthcare provider). The words "signature on file" can be inserted in place of the insured's or authorized person's signature.

Physician/Supplier Section

This section of the HICF form contains information the health professional must **gather** from the health record or the patient visit or both. When completing the HICF form, data for the date fields should be entered using the 8-digit (MM DD YYYY) format.

Block 14 – Enter the date of the first symptom of the current illness or injury in this block (if one is documented in the health record), or the date of the last menstrual cycle if the claim is related to a pregnancy. Use the 8-digit (MM DD YYYY) date format. Use caution here because an incorrect date could indicate a pre-existing condition, and the claim could be rejected. *Example*: If a patient was treated for a back injury before the effective date of his or her existing healthcare policy, this policy might not cover charges stemming from this same back injury.

Block 15 – Enter the first date the patient had the same or a similar illness using the 8-digit format. Leave blank if unknown.

Block 16 – If the patient is employed and is unable to work in current occupation, an 8-digit date must be shown for the "from - to" dates that the patient is unable to work. An entry in this field may indicate employment-related (workman's compensation) insurance coverage. Completion of this block is not required for most other carriers.

Block 17 – Enter the name (first, middle initial, last name) and credentials of the professional who referred, ordered, or supervised the services or supplies on the claim. Do not use periods or commas within the name. A hyphen can be used for hyphenated names. For laboratory and x-ray claims, enter the name of the physician who ordered the diagnostic services. Completion of this box also is required if billing for a consultation.

Block 18 – If the claim is related to a hospital stay, enter the dates of hospital admission and discharge. If the patient has not yet been discharged, leave the "to" box blank.

Block 19 – Enter the address of the referring provider as indicated in Block 17.

Block 20 – Enter an X in "YES" if the reported service was performed within the hospital. If "YES," enter the purchased price under "CHARGES." A "NO" mark indicates that the reported service was performed in a private lab and the purchase price should be entered under "CHARGES". The field may be left blank if no lab services were required.

Block 21 – Enter the patient's diagnosis using ICD-9-CM code numbers. If there is more than one diagnosis, list the primary diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in 23D by line number. When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit on top of the period.

Block 22 – Enter any relevant prior authorization numbers. The prior authorization number refers to the insurer's/insurance scheme's assigned number authorizing the service.

Block 23A – Enter dates of service ("from" and "to"). If there is only one date of service, enter that date under "From." If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. The number of days must correspond to the number of units in 23F. Submit each date of service on aerate line. Enter the month, day, and year (in the MM DD YYYY format) for each procedure, service or supply. When "From" and "To" dates are shown for a series of identical services, enter the number of days or units in 23F. Note: Only one procedure may be billed on each line. If there are more than six procedures, a second claim form needs to be used.

Block 23B – Enter the appropriate 2-digit code from the Place of Service Code list (Table 1) for each item used or service performed. The place of Service Code identifies the location

where the service was rendered. A more detailed list of Place of Service Codes is available at
http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf
Table 1 – List of place of service codes

Not all codes are applicable to Bermuda. A full listing can be accessed at:
http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf

Code	Place of Service
11	office
12	home
20	urgent care facility
21	inpatient hospital
22	outpatient hospital
23	emergency department – hospital
32	nursing facility
33	custodial care facility
34	hospice
41	ambulance – land
42	ambulance – air
51	inpatient psychiatric facility
55	residential substance abuse treatment facility
65	end stage renal disease treatment facility
71	state or local public health clinic
81	independent laboratory
99	other unlisted facilities

Block 23C – Enter the procedure, service, or supply code using appropriate 5-digit CPT code. Enter the 2- digit modifier when applicable. If using an unlisted procedure code (codes ending in "99"), a complete description of the procedure must be provided as a separate attachment. This field accommodates the entry of four 2-digit modifiers. The specific procedure codes must be shown without a narrative description.

Block 23D – Enter the diagnosis code reference number (pointer) as shown in Block 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number should be a 1, 2, 3, or 4; or multiple numbers as explained. (ICD-9CM diagnosis codes must be entered in Block 21 only; do not enter them in Block 23C). Enter numbers left justified in the field. Do not use commas between the numbers.

Block 23E – Enter the amount charged for each listed procedure, supply, or service. Ensure the dollar amount is reflected on the left hand side of Block 23E. Do not use commas when reporting dollar amounts. Negative dollar amount or "no charge" service is not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Block 23F – Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anaesthesia units or minutes, or oxygen volume. If only one service is performed, the number 1 must be entered. Enter numbers right justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point. If only one service is performed, enter the number 1. Do not leave blank.

Block 23G – For the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – related services, enter the response in the shaded portion of the field. Insurers should be contacted directly for clarification if this field applies to your services.

Block 23H – Enter the ID number of the healthcare provider delivering the service if required by the insurer/insurance scheme. In the case where a substitute provider *(locum tenens)* was used, enter that provider's information here.   Given that most of Bermuda's providers do not have an ID number, the name of the provider can be inserted or the field can be left blank.

Block 24 – Enter the patient's account number assigned by the provider's accounting system. Do not enter hyphens with numbers. Reporting the patient's account number in this block enables the insurer to print it on the explanation of benefits (EOB) and speeds data entry from the EOB.

Block 25 – Check the appropriate block to indicate whether the provider accepts assignment of benefits. The accept assignment indicates that the provider agrees to be reimbursed directly by the insurer/insurance scheme for services delivered to the patient.

Block 26 – Enter the total charges for services listed in Block 23E. Ensure that the dollar amount is reflected on the left hand side of Block 26. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Block 27 – Enter the total amount, if any, that the patient has paid. Leave blank if no payment has been made. See instructions for Block 26 for details on entering dollar amounts.

Block 28 – Enter total amount due. See instructions for Block 26 for details on entering dollar amounts.

Block 29 – Enter the legal signature of the provider and the 8-digit date (MM DD YYYY) the form was signed. Alternately, an electronic signature, the name of the professional who delivered the service, or the words "signature on file" can be inserted in this field. The office administrator or administrative assistant's name should not be inserted in this field.

Block 30 – Enter the name of the provider's business and the address that is submitting the claim.

Block 31 – Enter the professional grouping of the provider by placing a mark in the appropriate box. If the provider type is "OTHER", enter the profession.