Sagicor

DENTAL CLAIM FORM

28-48 Barbados Avenue, Kingston 5, Jamaica Tel: (876) 929-8920-9 Fax: (876) 929-4730/968-3232

1. Patient Name First M.I. Last	2. Relationship to Employee ☐ Self ☐ Child ☐ Spouse	3. Sex M F	4. Patient Birthdate MM DD YYYY

5. Employee Name	6. Health Card Number	7. Employer Name & Address	8. Group/Policy Number

9. Is patient covered by another Insurance Co.: ☐ Yes ☐ No If Yes, complete 9-a and 9-b	9-a. Name and Address of Other Carrier(s):	9-b. Other Group/Policy No.:

I hereby authorize the release of any information relating to this claim.

Signed (Patient or Parent, in minor) Date

I hereby authorize payment of the Dental benefits directly to the below named Dental provider.

Signed (Patient or Parent, if minor) Date

10. Name of Provider

11. Address where payment should be remitted:

City

12. Provider TRN:	13. Provider GCT No.	14. Provider Tel No.:

Remarks:

15. TO BE COMPLETED BY DENTIST:

-07 08 09 10-
-06 11-
-05 Upper 12-
-04 13-
-03 14-
-02 15-
-01 Right 35- Left 16-
-32 36- 17-
-31 37- 18-
-30 38- 19-
-29 20-
-28 Lower 21-
-27 22-
-26 25 24 23-

Date of Service	Tooth # or Letter	Surface	Description of Service	Procedure #	Charges

16. CERTIFICATION - THIS FORM MUST BE SIGNED BY THE PROVIDER OR AUTHORIZED PERSON

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

Signature of Provider or Authorized Person Provider Stamp

Date

GCT(if applicable) @16.5%	$
TOTAL CHARGE + GCT	$
INSURANCE PLAN PAYS	$
GCT ON INS. PAYMENT	$
TOTAL PAYABLE BY INS. CO.	$
MEMBER PAYS	$

PLEASE ATTACH ORIGINAL RECEIPTS TO ENSURE PROCESSING OF CLAIMS
CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST SERVICE DATE TO ENSURE PROMPT PROCESSING
SEE OVER FOR OPTICAL CLAIM FORM...

28-48 Barbados Avenue, Kingston 5, Jamaica Tel: (876) 929-8920-9 Fax: (876) 929-4730/968-3232

OPTICAL CLAIM FORM

1. Patient Name First M.I. Last	2. Relationship to Employee ☐ Self ☐ Child ☐ Spouse	3. Sex M : F	4. Patient Birthdate MM : DD : YYYY

5. Employee Name	6. Health Card Number	7. Employer Name & Address	8. Group/Policy Number

9. Is patient covered by another Insurance Co.: ☐ Yes ☐ No If Yes, complete 9-a and 9-b	9-a. Name and Address of Other Carrier(s):	9-b. Other Group/Policy No.:

I hereby authorize the release of any information relating to this claim.

Signed (Patient or Parent, in minor) Date

I hereby authorize payment of the Dental benefits directly to the below named Dental provider.

Signed (Patient or Parent, if minor) Date

10. Name of Provider

11. Address where payment should be remitted:

City

12. Provider TRN:	13. Provider GCT No.	14. Provider Tel No.:

Remarks:

15. TO BE COMPLETED BY OPTOMETRIST/OPTHALMOLOGIST:

Diagnosis	Date of Service	Description of Service	Treatment Code	Charge		Amount Paid by Patient	
		Examination					
		Type of Lens					
		Frames					
			GCT				
	TOTAL CHARGE PLUS GCT						

16. CERTIFICATION - THIS FORM MUST BE SIGNED BY THE PROVIDER OR AUTHORIZED PERSON

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

Provider Stamp Signature of Provider or Authorized Person Date

PLEASE ATTACH ORIGINAL RECEIPTS TO ENSURE PROCESSING OF CLAIMS

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST SERVICE DATE TO ENSURE PROMPT PROCESSING

SEE OVER FOR OPTICAL CLAIM FORM..