CG | BRITCAY

VISION/EYE CARE 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 via Email to Medical_KY@cgcoralisle.com or via Fax to 345 945 0658.

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

Provider Name _____ Contact No. (_____) _____

Mailing Address _____

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 British Caymanian Insurance Agencies Limited or 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 _____

CG | BRITCAY

VISION/EYE CARE CLAIM FORM

Health Insurance

PART 2 VISION PROCEDURE/DIAGNOSIS CODES & DECLARATION

✓	Code	Procedure/CPT Description	Fee
	92004	Examination - New Patient	
	92014	Examination - Established Patient	
	92081	Visual Field report	
	V2020	Frames	
	V2100	Single Vision Lenses	
	V2200	Bifocal Lenses	
	V2300	Trifocal Lenses	
	V2500	Contact Lenses	
	V2740	Tint	
	V2750	Anti-Reflective Coating	
	V2760	Scratch Resistent	
	V2781	Progressive Lenses	
✓	Code	ICD10 Diagnosis Description	Fee
	H52	Disorders of refraction and accommodation	
	H52.0	Hypermetropia	
	H52.03	Hypermetropia, bilateral	
	H52.1	Myopia	
	H52.13	Myopia, bilateral	
	H52.221	Regular astigmatism, right eye	
	H52.222	Regular astigmatism, left eye	
	H52.223	Regular astigmatism, bilateral	
	H52.4	Presbyopia	
	H53.02	Refractive amblyopia	
	Z01.0	Encounter for examination of eyes and vision	
	Z01.00	Encounter for eye exam w/o abnormal findings	
	Z01.01	Encounter for eye exam w abnormal findings	

Diagnosis (if not defined above):	Total Charges	
	Payment Made	

I, the Rendering Provider, certify that the statements on this form are true and complete to the best of my knowledge.

Signature_____ Date _____

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
PO Box 74, Grand Cayman, KY1-1102 Cayman Islands | Tel 345 949 8699 | Fax 345 945 0658 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

Rev. 09-22