

Premier Health

	. CL		

Claim No.____

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_Claims_TT@cgcoralisle.com or via Fax to 441 295 9036.

PART 1 To be completed by the EMPI	LOYEE/INSURE	D (please print)		
Full Name of Insured				
Effective and/or Termination Date (DD/MM/YY) _				
Group Policy No	Certificate No.			
Employer Name		Dental Plan	■ Basic	□ Comprehensive
Employer's Mailing Address				Tel. No
Full Name of Patient				
Patient's Mailing Address				Tel. No
Patient's Date of Birth (DD/MM/YY)		Patient's Gende	er 🗆 Male	☐ Female
Relationship to Insured ☐ Self ☐ Spo	ouse	□ Other		
If the patient has other Dental Insurance covera	age, provide name	e of policy holder ar	nd policy n	umber
DECLARATION:				
I hereby certify that the foregoing answers are or other persons who treated me, and all hospit regarding this claim to The Beacon Insurance C	als or other institu	utions, to furnish ful		
Patient's or Authorised Person's Signature				Date
I hereby authorise payment of the Insurance Be	enefit directly to t	he Dentist named b	elow for a	mounts otherwise payable to me.
Patient's or Authorised Person's Signature				Date
PART 2 To be completed by the ATTE	ENDING DENTIS	ST (please print)		
Name of Dentist				
Address of Dentist				
Dentist Society or T.I.N. (if applicable)	De	entist Licence No. (i	f applicable	e)
Specialist in □ Orthodontics □ Endodontics	□ Oral Surgery	☐ Periodontics	□ Other_	
Date of first visit in this current series (DD/MM/Y	Y) De	entist Tel. No		
TREATMENT DETAILS				
1. Please check if treatment is a result of 🔲 oc	cupational illness	□ injury □ moto	r accident	other accident
2. Are any services covered by another plan?	☐ Yes ☐ No	Details		
3. Are radiographs or models enclosed?	☐ Yes ☐ No	Details		
4. If Prosthesis, is this the initial replacement?	☐ Yes ☐ No	If No, give date of	prior repla	cement (DD/MM/YY)
5. Is this treatment for orthodontics?	☐ Yes ☐ No	If Yes, date service	commenc	ed (DD/MM/YY)
Date appliances placed (DD/MM/YY)	Mo	onths of treatment	remaining_	
6. Please tick and fill in amount: ☐ Statement of	f ACTUAL charge:	s or 🗆 Pre-treatmer	nt ESTIMAT	E of charges =

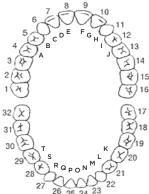


Premier Health

DENTAL CLAIM FORM

NOTES:

- 1. Examination Details to be completed on chart below.
- 2. Identify missing teeth with "X" on dental plan to right.
- 3. If services cannot be completed within 90 days from date of examination, patient must obtain a new authorisation and claim form for uncompleted services.
- 4. A pre-operative and post-operative x-ray of root canal work is required. Post-operative bite-wing x-rays must be provided when requested by The Beacon Insurance Company Limited.



PART 3 EXAMINATION AND TREATMENT PLAN

TOOTH No. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (Include x-rays, prophylaxis, materials used, etc.)	DATE OF SERVICE (DD/MM/YY)	PROCEDURE NUMBER	FEE	OFFICE USE ONLY
ı				TOTAL FEE CHARGED		
AXIMUM ALLOV	/ABLE					
EDUCTIBLE						
O-INSURANCE						
ARRIER PAYS*						
		rier Pays" are authorised. Payment will be made provided the tre on Date". Payment will be subject to all limitations and maximun		ed while the pa	tient is covere	ed as per
ART 4	DENTIS	ST'S CERTIFICATION FOR SERVICES PROVIDED)			
ave been	paid. 🗆 Y	es □ No I certify the above items (no. of items	_) were provide	d and comp	leted by me	9.
gnature_				Date		
ART 5	DECLA	RATION (To be signed by the Patient AFTER all	the work is co	omplete.)		
		e procedures as indicated by "Date of Service" have h				

I hereby certify that the procedures as indicated by "Date of Service" have been completed to my satisfaction.

The Beacon Insurance Company Limited 13 Stanmore Avenue, P.O. Box 837, Port of Spain 190211, Trinidad & Tobago Tel 868 225 1256 | medical claims tt@cgcoralisle.com | beacon.co.tt

Underwritten and administered by Coralisle Medical Insurance Company Ltd.

P.O. Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

A member of Coralisle Group Ltd.

Patient's Signature

Rev. 02-21

Date