Health Insurance Department
Overseas Health Insurance Claim Form

FOR OFFICAL USE

Coverage in force: Yes No
Plan HIP FC
Received By: ____________________
Date (d/m/y): ____________________

Policyholder Details (Please Print)

Name: **(Mr./Mrs./Miss./Ms.)** **(First Name)**

(Middle Name) **(Last Name)**

Mailing Address:

Parish: Postal Code:

Policy Number: Group Number:

Date of Birth (dd/mm/yy): / / Telephone Number: --

Email Address: ____

Claim Information: Please enter below each facility or provider that you received care services from while overseas.
***You must submit an invoice (bill) from each provider/facility, summary of care and/or physician notes, and receipt of any payments you have made. Incomplete claims submission will be denied.**

Facility or Provider Name (enter one claim item per line)	Date of service (dd/mm/yy)
1.	
2.	
3.	
4.	

Did you contact GMMI prior to, or if emergency, within 48 hours of receiving treatment? Yes No

Medical reason for care or diagnosis: ____

If due to accident, give date (dd/mm/yy): / /

Do you have any other health plan coverage, USA Medicare/Medicaid or National Health Care Plan? Yes No

If "Yes", please provide Name of Insurer or Health Plan: ________________________________

Policy Number : ________________________________

I hereby authorize my medical service provider to release medical information and/or documentation to the Health Insurance Department on my behalf to expedite the payment of insurance claims.

Signed: ________________________________ Date (dd/mm/yy): ____________________

(Policyholder Signature)

Street Address – Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Mailing Address – PO Box HM 2160, Hamilton HM JX Bermuda
Phone: (441) 295-9210 Fax: (441) 295-9213 Email: hip@gov.bm Website: www.hip.gov.bm

Health Insurance Department
Health Insurance Plan / FutureCare Plan
Direct Deposit Request Form

FOR OFFICAL USE	
Reviewed By:	
Date (d/m/y):	
HID Manager Signature:	
Processed:	Yes No

This Direct Deposit Request Form is to be used for local Bermuda claims only.

Please complete all fields, printing or typing information clearly

Contact Details	
Policyholder Name:	
Policy/Group ID:	
E-mail:	
Telephone (direct):	
Mailing Address (for Correspondence):	

Bank Details	
Bank Name: **(Bermuda Banks Only)**	
Name on Bank Account:	
Bank Account Number:	
Account Type: **(Chequing or Saving)**	

I hereby authorize the Health Insurance Department to satisfy payment obligations due to me/the Business Organization, by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the Health Insurance Department's payment obligation for the full amount on the date the fund transfer is completed. All correspondence with the Health Insurance Department concerning this agreement or any changes to account information should be sent to the address at the top of this form.

PRINT NAME: ____

SIGNATURE:_________________________ **DATE:** _________________________

PLEASE NOTE THAT ANY CHARGES INCURRED BY THE GENERATION OF ELECTRONIC PAYMENTS WILL NOT BE CHARGED TO THE CLIENT. ALL FEES STRICTLY RELATED TO THE PROCESSING OF ELECTRONIC PAYMENTS ARE THE SOLE RESPONSIBILITY OF THE HEALTH INSURANCE DEPARTMENT.

Street Address – Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Mailing Address – PO Box HM 2160, Hamilton HM JX Bermuda
Phone: (441) 295-9210 Fax: (441) 295-9213 Email: hip@gov.bm Website: www.hip.gov.bm