Health Claims Submission:

A health claim is submitted for an insured person when expenses are incurred for medical, dental or vision care. Incomplete claim forms require the Insurer to set aside the submitted documents for further investigation and clarification of charges, services or details. This can cause unnecessary delays in finalizing settlement.

Below are some examples of incomplete items that can delay settlement of claims:-

- **Copies of receipts or invoices accompanying original claim forms**
- **Cash register slip –Insurers require an itemized drug bill**
- **The amount on the receipt does not match the amount itemized on the completed claim form**
- **There are no receipts to support the completed claim form**
- **A receipt from hospital services is submitted but there is no itemized hospital bill**

For proper submission of a health claim the covered person should ensure the following are completed:

1. The attending physician section of the claim form – this section is usually completed by the health care provider – indicating the
    i. **Diagnosis - condition(s) treated**
    ii. **Type of and date of service(s)**
    iii. **The charge(s) for services rendered**
    iv. **Any further services recommended**
    v. **Clearly stating any drugs prescribed or drugs or injections given in office at the time of the visit**
    vi. **the procedure performed, if any, during the visit**

    You can use a claim form from any insurer to submit your claim or you can use ATTIC's Claim form www.attic.org.tt

2. The Insured section of the claim form – this section is completed by the covered person, clearly stating the following:
    i. **First name, surname and date of birth of insured**
    ii. **First name, surname and date of birth of patient (if patient is a dependent)**
    iii. **Insured or Patient's address and contact numbers**
    iv. **State details of whatever treatment or condition is related to an accident**
    v. **Whether the insured or patient is covered by any other plan which provides similar benefits**
    vi. **If benefits are being assigned to an institution – state the name of the payee**
    vii. **Date and Signature of the covered person (Primary insured)**

3. **ORIGINAL receipts** and itemized invoices or bills must be submitted to accompany the charges stated on the **original completed claim form**.

Coordination of Benefits - Coverage under more than one Health Plan

Coordination of benefits allows the insured to recover from more than one Health Plan, up to 100% of eligible expenses incurred for any medical, dental or vision treatment.

The insured or patient **does not have to submit two original sets of claim forms**.

Only one claim submission is required when an insured is covered under more than one Health Plan.

The following is the process for settlement of claims where coordination of benefits exist (i.e. coverage under more than one Health Plan):

1. Submit the original claim form to the Insurer responsible for the initial claim settlement i.e. (The Primary Insurer),
2. The insured who is covered under another health plan with similar benefits (Coordination of Benefits), should complete the section of the claim form indicating the name of other Insurer (The Secondary Insurer).
3. The Primary Insurer makes settlement of the eligible amount under the Primary health plan
4. After settlement of the eligible expenses, the Primary insurer sends copies of the claim forms and claims worksheet (showing amount paid) to the Secondary Insurer.
5. The Secondary Insurer pays the eligible difference – allowing the insured to recover up to 100% of eligible expenses incurred.