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w: www.icbl.com

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*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Samuel Jhata
2. (a) INSURED'S ADDRESS: Karivera Apmaku
- (b) TELEPHONE (INCLUDING AREA CODE): 5
- (c) EMAIL ADDRESS: Samuel143@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 8/5/1983 (b) GENDER (MALE/FEMALE): F
4. (a) INSURED'S POLICY NO.: 1034VBS
- (b) INSURED'S CERTIFICATE NO.: 1034 VBS
5. EMPLOYER'S/ GROUP'S NAME: Self
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) ✓
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL) : _____ (If "YES" please complete 7a -7c)
- (b). OTHER INSURED POLICY OR GROUP NUMBER : _____
- (c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): Balamysil
9. PATIENT'S ADDRESS: Apmaku Kurrool AP
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 16/ Septe /1975 (b) GENDER (MALE/FEMALE): F
11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD
12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO): ✓
B. AUTO ACCIDENT (YES/NO): _____ C. OTHER ACCIDENTS (YES/NO): _____
Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Pravardik SPOUSE (IF PATIENT) NO DATE (DD/MM/YY): 5/9/2020

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: _____ COMPANY STAMP: _____ DATE (DD/MM/YY): _____

INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 5/5/2020

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 5/3/2020

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. Raghu naidu.

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Heart Problem 2. Heart problem

20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): 20000

21.

I. DATE OF SERVICE (DD/MM/YY): <u>7/3/2019</u> PLACE OF SERVICE OFF/HOSP/HOME: <u>Home</u> (PROCEDURES, SERVICES OR SUPPLIES CODE: <u>EMR</u> (Explain Unusual Circumstances) DIAGNOSIS CODE (1,2): <u>2</u> CHARGES(\$): <u>10000</u> UNITS FOR DAYS: <u>10</u> FURTHER SERVICES RECOMMENDED: <u>No</u>	II. DATE OF SERVICE (DD/MM/YY): <u>7/3/2019</u> PLACE OF SERVICE (OFF/HOSP/HOME): <u>Home</u> PROCEDURES, SERVICES OR SUPPLIES CODE: <u>EMR</u> (Explain Unusual Circumstances) DIAGNOSIS CODE (1,2): <u>2</u> CHARGES(\$): <u>10000</u> UNITS FOR DAYS: <u>10</u> FURTHER SERVICES RECOMMENDED: <u>No</u>
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ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): ✓

23. TOTAL CHARGED (\$): _____ 24. AMT PAID (\$): 5000 25. BALANCE DUE: 5000

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Dr. Raghu naidu.

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Home

28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
Dr. Raghu naidu.

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

29. I authorize payment of medical benefits to:

Hospital: Govt Hospital Doctor/Surgeon: General physician

Signature: Dr. Renu Date (DD/MM/YY): 10/3/2019



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MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Navayen Hosen
2. (a) INSURED'S ADDRESS: Kop Vera Afimaku
- (b) TELEPHONE (INCLUDING AREA CODE): ✓
- (c) EMAIL ADDRESS: Navayen123@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 07/07/1983 (b) GENDER (MALE/FEMALE): ✓
4. (a) INSURED'S POLICY NO.: SIBSC 1090
- (b) INSURED'S CERTIFICATE NO.: SIBSC 1090
5. EMPLOYER'S/ GROUP'S NAME: Self
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) ✓ (If "YES" please complete 7a -7c)
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____
- (b). OTHER INSURED POLICY OR GROUP NUMBER : _____
- (c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): Pravinkar
9. PATIENT'S ADDRESS: Kadapau, AP
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 9/August/2013 (b) GENDER (MALE/FEMALE): ✓
11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD
12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO): ✓
B. AUTO ACCIDENT (YES/NO): _____ C. OTHER ACCIDENTS (YES/NO): _____
Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Pravinkar SPOUSE (IF PATIENT) No DATE (DD/MM/YY): 5/8/2020

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: _____ COMPANY STAMP: _____ DATE (DD/MM/YY): _____

INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 1/3/2020

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 1/3/2020

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. Chinnayyah

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Stomach 2. Stomach

20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): 75,000

21.

I. DATE OF SERVICE (DD/MM/YY): <u>7/3/2020</u> PLACE OF SERVICE OFF/HOSP/HOME): <u>Home</u> (PROCEDURES, SERVICES OR SUPPLIES CODE: _____ (Explain Unusual Circumstances) DIAGNOSIS CODE (1,2): <u>2</u> CHARGES(\$): <u>75,000</u> UNITS FOR DAYS: <u>20</u> FURTHER SERVICES RECOMMENDED: <u>NO</u>	II. DATE OF SERVICE (DD/MM/YY): <u>7/3/2020</u> PLACE OF SERVICE (OFF/HOSP/HOME): <u>Home</u> PROCEDURES, SERVICES OR SUPPLIES CODE: <u>same</u> (Explain Unusual Circumstances) DIAGNOSIS CODE (1,2): <u>2</u> CHARGES(\$): <u>75,000</u> UNITS FOR DAYS: <u>20</u> FURTHER SERVICES RECOMMENDED: <u>NO</u>
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ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): ✓

23. TOTAL CHARGED (\$): _____ 24. AMT PAID (\$): 70,000 25. BALANCE DUE: 5000

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Raghunath Chinnayyah

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Home

28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
Dr. R Chinnayyah

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: Govt Hospital Doctor/Surgeon: General physician

Signature: ✓ Chinnayyah Date (DD/MM/YY): 16/3/2020



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MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Sandeep
2. (a) INSURED'S ADDRESS: Ramnagar Hyd
- (b) TELEPHONE (INCLUDING AREA CODE): -
- (c) EMAIL ADDRESS: T Battina @ gmai.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 4/may/2009 (b) GENDER (MALE/FEMALE):
4. (a) INSURED'S POLICY NO.: 10954VBI
- (b) INSURED'S CERTIFICATE NO.: 10954VBI
5. EMPLOYER'S/ GROUP'S NAME: Self employ
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO)
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)
- (b). OTHER INSURED POLICY OR GROUP NUMBER : _____
- (c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): Sureen Kunej
 9. PATIENT'S ADDRESS: Ramnagar Hyd
 10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 15/Aug/1950 (b) GENDER (MALE/FEMALE):
 11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD
 12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO):
B. AUTO ACCIDENT (YES/NO): _____ C. OTHER ACCIDENTS (YES/NO): _____
- Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Sureen Kunej SPOUSE (IF PATIENT) Fatney DATE (DD/MM/YY): 15/Aug/1950

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: Sureen Kunej COMPANY STAMP: Police department DATE (DD/MM/YY): 15/Aug/1950



INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 17/May/2019

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 16/march/2019

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. liver proble

2. Body effect

20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): 70,000

21.

I.

DATE OF SERVICE (DD/MM/YY): 18/May/2019

PLACE OF SERVICE (OFF/HOSP/HOME): HOSP

(PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 2

CHARGES(\$): 71alic

UNITS FOR DAYS: 30

FURTHER SERVICES RECOMMENDED: No

II.

DATE OF SERVICE (DD/MM/YY): 18/May/2019

PLACE OF SERVICE (OFF/HOSP/HOME): HOSP

(PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 2

CHARGES(\$): 71alik

UNITS FOR DAYS: 30

FURTHER SERVICES RECOMMENDED: No

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): Yes

23. TOTAL CHARGED (\$): _____ 24. AMT PAID (\$): 70,000 25. BALANCE DUE: 70,000 - 60,000

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):

DR. HariKrishna

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):

General physician

28. PHYSICIAN'S, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:

Dr. HariKrishna

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: yelaguda Hospital Doctor/Surgeon: HariKrishna

Signature: HariKrishna Date (DD/MM/YY): 20/May/2019



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MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Satya Syam

2. (a) INSURED'S ADDRESS: Dharmaji guelam

(b) TELEPHONE (INCLUDING AREA CODE): _____

(c) EMAIL ADDRESS: Satya Syam@gmail.com

3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 18/Nov/1991 (b) GENDER (MALE/FEMALE):

4. (a) INSURED'S POLICY NO.: SVB 1030

(b) INSURED'S CERTIFICATE NO.: SVB 1030

5. EMPLOYER'S/ GROUP'S NAME: Self employ

6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO)

7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)

(b). OTHER INSURED POLICY OR GROUP NUMBER : _____

(c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): S. Bhay koy Rao

9. PATIENT'S ADDRESS: Dharmaji guelam

10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 12/4/1950 (b) GENDER (MALE/FEMALE):

11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO):

B. AUTO ACCIDENT (YES/NO): _____

C. OTHER ACCIDENTS (YES/NO): _____

Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Bhay koy Rao SPOUSE (IF PATIENT) Father DATE (DD/MM/YY): 12/4/1950

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: Bhay koy COMPANY STAMP: gov General DATE (DD/MM/YY): 12/4/1950



INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 19/10/2009
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): _____
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:
1. Kidney effect
2. Kidney problem
20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): 20,000.

21.

I.

DATE OF SERVICE (DD/MM/YY): 20/10/2009
PLACE OF SERVICE (OFF/HOSP/HOME): Home
(PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 25000
UNITS FOR DAYS: 30
FURTHER SERVICES RECOMMENDED: NO

II.

DATE OF SERVICE (DD/MM/YY): 20/10/2009
PLACE OF SERVICE (OFF/HOSP/HOME): Home
(PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 25000
UNITS FOR DAYS: 30
FURTHER SERVICES RECOMMENDED: NO

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): Yes

23. TOTAL CHARGED (\$): _____ 24. AMT PAID (\$): 50,000 25. BALANCE DUE: 5000. 15,000

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
B. Hari Rao

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Kakinada Town (A.P)

28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
Girish Narayana

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: Govt Hospital Doctor/Surgeon: General Surgeon
Signature: Girish Narayana Date (DD/MM/YY): 25/10/2009



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MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Sun Karmal
2. (a) INSURED'S ADDRESS: Atmakur Kurnoor.
(b) TELEPHONE (INCLUDING AREA CODE): -
(c) EMAIL ADDRESS: 1 Sun karmal @ gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 18/feb/1950 (b) GENDER (MALE/FEMALE):
4. (a) INSURED'S POLICY NO.: 80TV 1020
(b) INSURED'S CERTIFICATE NO.: 80TV 1020
5. EMPLOYER'S/ GROUP'S NAME: Pelt employ
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) NO
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)
(b) OTHER INSURED POLICY OR GROUP NUMBER : _____
(c) OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): Koilath
9. PATIENT'S ADDRESS: Atmakur Kurnoor.
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 15/6/1991 (b) GENDER (MALE/FEMALE):
11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD
12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO):
B. AUTO ACCIDENT (YES/NO): _____ C. OTHER ACCIDENTS (YES/NO): _____
Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Koilath SPOUSE (IF PATIENT) Spous DATE (DD/MM/YY): 19/10/2008

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: T. Wilson COMPANY STAMP: Monetary DATE (DD/MM/YY): 19/10/2008

INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 19/8/2008

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): _____

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. peri ureter problem 2. urinary problem

20. OUTSIDE LAB? (YES/NO): ✓ CHARGES (\$): 1000

21.

I.

DATE OF SERVICE (DD/MM/YY): 20/8/2008

PLACE OF SERVICE (OFF/HOSP/HOME): HOSP

(PROCEDURES, SERVICES OR SUPPLIES CODE: un usual

(Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 2

CHARGES(\$): 1000

UNITS FOR DAYS: 5

FURTHER SERVICES RECOMMENDED: _____

II.

DATE OF SERVICE (DD/MM/YY): 20/8/2008

PLACE OF SERVICE (OFF/HOSP/HOME): HOSP

PROCEDURES, SERVICES OR SUPPLIES CODE: un usual

(Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 2

CHARGES(\$): 1000

UNITS FOR DAYS: 5

FURTHER SERVICES RECOMMENDED: _____

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): 20/8/2008

23. TOTAL CHARGED (\$): 1000 24. AMT PAID (\$): 500 25. BALANCE DUE: 500

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Pagmarach

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Home

28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
9346070854

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: Govt Hospital Doctor/Surgeon: Pagmarach

Signature: Grenard Pangam Date (DD/MM/YY): 20/8/2008



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Carlton Complex, Black Rock, St. Michael
t: (246) 434-6008 / f: (246) 434-6099

*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Gowthami
2. (a) INSURED'S ADDRESS: PTC X Road
- (b) TELEPHONE (INCLUDING AREA CODE): -
- (c) EMAIL ADDRESS: 123gouri@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 27/8/1989 (b) GENDER (MALE/FEMALE):
4. (a) INSURED'S POLICY NO.: 1050 80 PRV.
- (b) INSURED'S CERTIFICATE NO.: 1050 .80 PRV.
5. EMPLOYER'S/ GROUP'S NAME: Self employe
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO)
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)
- (b). OTHER INSURED POLICY OR GROUP NUMBER : _____
- (c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY): _____

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): S. Turveshni
9. PATIENT'S ADDRESS: 6-7-14 Bansidhar pet. hyd
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 31/12/1970 (b) GENDER (MALE/FEMALE):
11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD
12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO):
B. AUTO ACCIDENT (YES/NO):
C. OTHER ACCIDENTS (YES/NO):
Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Turveshni SPOUSE (IF PATIENT) NA DATE (DD/MM/YY): 30/8/1970

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: Turveshni COMPANY STAMP: Hanover DATE (DD/MM/YY): 30/8/1970

INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 10/8/2010 10/8/2010.

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): _____

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Kidney 2. Kidney problem

20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): 10,000

21.

I.
DATE OF SERVICE (DD/MM/YY): 11/8/2010
PLACE OF SERVICE (OFF/HOSP/HOME): Home
(PROCEDURES, SERVICES OR SUPPLIES CODE: unspec
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 10500
UNITS FOR DAYS: 60
FURTHER SERVICES RECOMMENDED: _____

II.
DATE OF SERVICE (DD/MM/YY): 11/8/2010
PLACE OF SERVICE (OFF/HOSP/HOME): Home
PROCEDURES, SERVICES OR SUPPLIES CODE: unspec
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 10500
UNITS FOR DAYS: 60
FURTHER SERVICES RECOMMENDED: _____

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): 11/8/2010

23. TOTAL CHARGED (\$): 10500 24. AMT PAID (\$): 5000 25. BALANCE DUE: 5500

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Medwin Hospital

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Medwin Hospital

28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
9204367154

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: Medwin Hospital Doctor/Surgeon: Girish Navayyan

Signature: Giri Date (DD/MM/YY): 10/8/2010



Always there
when you need us most

Head Office:
Roebuck St., St. Michael
P.O. Box 1221, Bridgetown,
BB11000, Barbados
t: (246) 434-6000 / f: (246) 426-3393
e: icb@icb.com.bb
w: www.icbl.com

VAT Registration Number:
20092283

Branch Offices:
Emerald City, Six Roads, St. Philip
t: (246) 434-6009 / f: (246) 434-6098
Carlton Complex, Black Rock, St. Michael
t: (246) 434-6008 / f: (246) 434-6099

*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Kailash

2. (a) INSURED'S ADDRESS: Hyderabad

(b) TELEPHONE (INCLUDING AREA CODE):

(c) EMAIL ADDRESS: Kailash thakur@gmail.com

3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 15/10/1990 (b) GENDER (MALE/FEMALE):

4. (a) INSURED'S POLICY NO.: _____

(b) INSURED'S CERTIFICATE NO.: _____

5. EMPLOYER'S/ GROUP'S NAME: Drivey

6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) NO

7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)

(b). OTHER INSURED POLICY OR GROUP NUMBER :

(c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY):

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): Salamma

9. PATIENT'S ADDRESS: Kesivern, Aimaku, Kurroob

10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 17 Jan 1950 (b) GENDER (MALE/FEMALE):

11. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO):

B. AUTO ACCIDENT (YES/NO):

C. OTHER ACCIDENTS (YES/NO):

Kindly describe on a separate sheet

DECLARATION BY THE INSURED

13. I hereby certify that the foregoing answers are true and correct to the best of my knowledge and I authorize all doctors and other persons who treated me or all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to INSURANCE CORPORATION OF BARBADOS LIMITED.

SIGN: INSURED Salamma SPOUSE (IF PATIENT) NO DATE (DD/MM/YY): 17/Jan/1950

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): _____ Effective Date of Dependant's coverage (DD/MM/YY): _____

SIGNED: Salma COMPANY STAMP: Manu DATE (DD/MM/YY): 17/Jan/1950

INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 9/9/2020
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): _____
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:
1. body effect
2. body pain
20. OUTSIDE LAB? (YES/NO): _____ CHARGES (\$): _____

21.

I.

DATE OF SERVICE (DD/MM/YY): 9/9/2020
PLACE OF SERVICE OFF/HOSP/HOME): Home
(PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 500
UNITS FOR DAYS: _____
FURTHER SERVICES RECOMMENDED: 300

II.

DATE OF SERVICE (DD/MM/YY): 9/9/2020
PLACE OF SERVICE (OFF/HOSP/HOME): Home
PROCEDURES, SERVICES OR SUPPLIES CODE: unusual
(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2
CHARGES(\$): 500
UNITS FOR DAYS: _____
FURTHER SERVICES RECOMMENDED: 300

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): 10/9/2020.
23. TOTAL CHARGED (\$): 500 24. AMT PAID (\$): 300 25. BALANCE DUE: 200

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Art collage Hyderabad

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Bondha nayag Hyderabad

28. PHYSICIAN'S, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
9133939654

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: Clinick Doctor/Surgeon: Dr Rammu
Signature: Dr Rammu Date (DD/MM/YY): 9/9/2020