CG | INSURANCE

COMMERCIAL PRESCRIPTION DRUG CLAIM

Claim No._____

Premier Health

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF DATE PRESCRIPTION FILLED.

Please submit completed form along with receipts (do not staple to form) via Email: Medical_claims_BM@cgcoralisle.com or Fax: 441 295 9036

PART 1 PRIMARY INSURED

Surname _____ First Name _____ Middle Initial _____

Certificate No._____ Date of Birth (DD/MM/YY)_____

Mailing Address _____

Contact Nos. (H)_____ (W) _____ (C) _____

PART 2 PRESCRIPTION(S) WERE FOR

Surname _____ First Name _____ Middle Initial _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child Date of Birth (DD/MM/YY)_____

Is the patient covered by additional health insurance coverage? ☐ Yes ☐ No If Yes:

Other Carrier Name _____ (please include EOB of this Carrier)

PART 3 PHARMACY INFORMATION

Name of Pharmacy _____

Address _____ Tel. No._____

DATE	RX NO.	DRUG ID (if given)	QTY	DESCRIPTION	PRICE
				Total Charges	

PART 4 DECLARATION

I hereby certify that the above is correct and complete and that I am claiming benefits only for the charges for the patient named above.

Primary Insured's Signature _____ Date _____

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda
PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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