CLAIM FORM

IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM OR ANY OTHER ASPECTS OF YOUR COVER, PLEASE CALL THE NUMBER ON THE BACK OF YOUR INSURANCE CARD.

DETAILS OF POLICY HOLDER/PATIENT:

Policy Holder´s Name: Date of Birth:

Patient´s Name and Address:

Tel Number: Fax Number:

Email Address: Claim Number:

Patient´s Relationship to Member: Membership Number from your card:

Date received
(TPA use only)

MEDICAL SECTION (To be fully completed by patient´s medical practitioner - all boxes must be completed in block capitals)

Medical Practitioner´s Name and Address

Date symptoms first noticed by patient

Tel Number

Fax Number

I declare that I am the patient´s practitioner, and that the particulars given are to be the best of my knowledge true and correct.

Signature Date

Medical Practitioner´s Stamp

Medical Condition requiring treatment

Please give the date on which your patient first presented to any doctor for this condition

Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates. Please also advise any further treatment planned.

OTHER INSURER´S DETAILS

(If the treatment is accident-related or covered under another insurance policy please provide name of insurance company)

DETAILS FOR CLAIM SETTLEMENT

Please indicate how you would like the claim settlement to be made: ☐ By Electronic Transfer ☐ By Cheque
For electronic transfer, please complete the below:

Account beneficiary name:______ Account number:______ Bank name:______

Bank address:______ IBAN number:______ Swift code:______

Email address:______ Mobile number:______

PATIENT´S DECLARATION AND CONSENT

I confirm that I am the patient/patient´s parent or guardian (if patient under 16 years of age) and wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient´s care to discuss treatment details and discharge arrangements with and to insurance company and TPA. I agree that a copy of this consent shall have the validity of the original.

Signature

Date

The claim form must be submitted within 120 days from start date of the treament along with all original receipts/invoices - as per the policy agreement. Claims will not be considered if not submitted within 120 days of treatment being received. Missing documents must be resubmitted within 60 days from date request for missing documents has been sent.

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