GlobalCare Insurance Plans

Claim Form

Reinsured through: Hanse Merkur Insurance Group

For questions about making a claim please call the relevant 24/7 Helpline found on the back your card

Patient Details (the insured person claiming for a treatment, service and/or supply)

Patient's Full Name:

Member ID *(as shown on card)*: **Date of Birth:** DD / MM / YYYY

***Email:** ***Phone:**

**If you are a parent or legal guardian completing this form on behalf of a dependant please provide your own contact details.*

Provider Details (to be completed by the Provider/Practioner providing any treatment, service and/or supply)

Practioner's Name, Details and/or Stamp:

Phone: _____

Reason for visit/claim: _____

_____

_____

Date Received (Official use only)

ONLY to be completed by Medical & Dental Practioners:

***Condition/complaint:** _____

***Date symptom(s) first noticed by patient:** _____

***History:** _____

_____

***Diagnosis:** _____

_____

***ALL treatments and/or services provided:** _____

_____

***Any planned further treatment/prescriptions issued:** _____

I declare I am the patient's Practioner and the details provided above are to the best of my knowledge true and correct: **Signature:** _____ **Date:** DD / MM / YYYY

Other Insurance: Could this claim be covered by another insurance policy? Yes: ☐ or No: ☐

If **Yes**, please give details, including the name of the other insurer: _____

Declaration & Consent:

I confirm I am the patient (or the patient's parent/legal guardian if the patient is under 18 years of age) and wish to make a claim as per this form and all attached receipts and invoices. I declare that all particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the Practioner/Provider to communicate freely and share any information with the Insurer or TPA as may be requested to authenticate and process this claim.

Name:

Date: DD / MM / YYYY **Signature:**

Please provide your payment details on Page 2

IMPORTANT NOTE - FAILURE TO COMPLY MAY INVALIDATE OR DELAY YOUR CLAIM! This form must be duly completed by both the patient and the attending practioner, when visiting any type of provider (medical, dental or optical) that is not in the patient's assigned network. Claim forms MUST be submitted with copies of any related discharge summaries, medical reports, diagnostic results/reports, prescriptions, invoices and/or receipts. For ongoing treatment of a medical condition (e.g. a program of physiotherapy sessions), subsequent invoices/receipts shold be submitted with a copy of the orginal completed claim form. The insurer may request original versions of submitted documents so keep them safe. Claims must be submitted within 180 days from the date the cost was incurred. Missing documents or information must be submitted within 60 days of being requested.

Bank Details

Reimbursements are only possible by bank transfer.

Patient's Name: _____

Patient's Member ID: _____

Dependant's claims can only be reimbursed to the principal member (the person who set up the policy or for group policies the employee).

Payments will be in the currency of the patient's country of residence.

Expenses incurred in a foreign currency will be converted into the currency of the Country of Residence of the patient at the exchange rate on the date of any invoice or receipt.

If you would like the payment to be made into the same bank account used for your last claim, please tick the box: ☐

If not, or if this is your first claim with us, please provide the following:

Beneficiary Name: _____

IBAN: _____

Bank Name: _____

Signature: _____ Date: DD / MM / YYYY