

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:	Date received (TPA use only)
Patient's Name and Address:		
Tel Number:	Fax Number:	
Email Address:	Claim Number:	
Patient's Relationship to Member:	Membership Number from your card:	

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
Please complete the following form to enable claim settlement: Reimbursement Claim and Bank Details Form EIC.

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.

The claim form must be submitted within 120 days from start date of the treatment 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.

Signature
Date