Claim Form

PROCEDURE FOR FILING A CLAIM

1) In order to make the process of claiming as simple and straight forward as possible. Please complete this form as comprehensively as you can. This way, we can process your claim most efficiently, enabling us to speed up the process of reimbursement. The form should be used for only one individual and one event at a time.
2) **Answer all questions on both sides of the claim form and attach to it the ORIGINALS of all reimbursable bills.** Bills should indicate name of patient, date of treatment, and where possible, a detailed description of medical services and the amount of charges corresponding to each category of treament or service. Pharmacy bills should identify drugs purchased (name and cost per item). Bills must specify name and address of medical provider or pharmacy. Cash receipts which do not provide this information are NOT acceptable.
3) Bills for eyeglasses, contact lenses, prescription drugs, lab tests, physical therapy must be accompanied by a copy of the **prescription**.
4) **In all cases, you must have your physician, doctor or dentist sign and complete page 2 on the reverse of this form.**
5) Please ensure that this claim form is sent to us no later than 3 months after the date of service to which this claim relates. (i.e., if your treatment occurs on the 15th March, your claim must be received by us before the 15th June).
6) Are you, the policyholder, covered under any other group plan, H.M.O., Social Security or Government Plan, or individual insurance policy, which will pay any of these expenses of this claim? ☐ NO ☐ YES, please identify plan and describe benefits:

_____

A. Claimant

1) Family Name: _____ 2) First Name: _____
3) Group: _____ 4) Policy ID/Number: _____
5) Tel No: _____ 6) E-mail Address: _____
7) Is the claim the result of an accident? ☐ NO ☐ YES

Date of Treatment	List & Description of Expenses	Currency & Amount Claimed	Reimbursable Currency
		Total	

Should you run out of space, please attach a new page with your other list of expenses.

8) Is this your first claim for this medical condition? ☐ NO ☐ YES
9) How long have you had these symptoms before consulting your doctor? _____
10) Please describe the medical symptoms you wish to claim for: _____

PAYMENT DETAILS (You have 2 options in which we can deal with your reimbursement)

Option 1 (Pay you directly - Please choose which payment method you would prefer along with any banking details if relevant.)

☐ Payment direct to policyholder ☐ Payment in invoice currency ☐ Other currency (please specify): _____

Account Beneficiary Name: _____ Sort / Branch code: _____
Name of bank: _____ Account No. / IBAN: _____
Address of bank: _____ _____
_____ SWIFT code: _____

Option 2 (Your Provider of Medical Services: e.g. Hospital, Specialist)

☐ Payment to Provider of Medical Service ☐ Please tick if direct billing has been previously agreed with Claims Dept.

I hereby certify that the information provided is correct and true to the best of my knowledge. I also confirm that if this claim relates to a pre-existing condition that has not been accepted b y the insurer in writing, it may not be approved for payment. I understand that in the event that this claim being misleading or fraudulent, in whole or part, the policy will be invalidated.

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company, or other person or firm to provide HealthCare International or their authorised representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to all medical and mental illness or use of drugs or alcohol.

In order to process this claim for benefits, I authorise the release to HealthCare International or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photo copy of this authorisation shall be considered as effective and valid for the duration of this claim. I understand that I have the right to receive a copy of this authorisation.

Signed by Insured: _____ (Relationship if signed by other than Patient): _____ Date: _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

B. Medical Claim (To be completed by your treating doctor/dentist or specialist)

1) Has pre-authorisation been obtained? ☐ No ☐ Yes 2) Has the treatment been concluded? ☐ No ☐ Yes

3) Indicate type of treatment received? ☐ Elective ☐ Emergency ☐ Routine

4) Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV: _____

_____

_____

5) On what date did the patient first present these symptoms to you? Date (dd/mm/yy): _____

6) Prior to consulting you, when did the patient first notice signs or symptoms of this medical/dental condition? Date (dd/mm/yy): _____

7) Are you aware of any treatment given for this or any related illness in the past? ☐ No ☐ Yes ☐ N/A

If yes, please provide details of the treatment: _____

_____

_____

8) Have you referred this patient to a specialist? ☐ No ☐ Yes, please provide full contact details of the specialist: _____

_____

9) Has the insured person undergone a routine dental check in the past 6 months? ☐ No ☐ Yes

10) Has the insured person had any treatment in the past 6 months? ☐ No ☐ Yes, what treatment was carried out? _____

_____

11) Has all the treatment been concluded? ☐ No ☐ Yes If No , please provide a treament plan: _____

_____

12) Is the claim for Emergency Dental treatment? ☐ No ☐ Yes, confirm date and time of accident, injury and the treatment plan: _____

_____

_____

C. Provider Contact Details (To be completed by your treating doctor/dentist or specialist)

1) Name of doctor/dentist: _____ 2) Qualifications/credentials: _____

3) Name of hospital/clinic: _____ 4) E-mail: _____

5) Telephone: _____ 6) Fax: _____

7) Address: _____

Please sign and authenticate with an official stamp.

Medical or Dental Practice Stamp

Signature of Doctor: _____ Date (dd/mm/yy): _____

The confidentiality of patient and member information is of paramount concern to HealthCare International. HealthCare International fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have the right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

If you are not completely satisfied with the level of service received or the outcome of a claim from HealthCare International then please contact our Customer Care Team by email, customercare@healthcareinternational.com or telephone +44 (0)207 590 8801. They will be happy to discuss this with you.

Please Send Claim Form To The HealthCare International Claims Administration Office

HealthCare International
HCI 24:7 Claims Administration Office

Tel: +44 (0)20 7590 8816 Fax: +44 (0)20 7590 8819
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