

claims@healthcareinternational.com



healthcareinternational.com



Medical Claim Form

Important information - please read carefully

whole or part, the claim may be rejected and could lead to the policy being invalidated.

the right to receive a copy of this authorisation.

Signature:

including without limitation, information relating to all medical and mental illness or use of drugs or alcohol.

- The form should be submitted to us within three months of the initial treatment date.
- A separate form should be completed for each claimant and each event/condition.
- You must fully complete, in BLOCK CAPITALS, and sign page one. Your treating doctor/specialist must fully complete and sign page two. Failure to fully
 complete the form may result in delays with processing your claim.
- We accept scanned copies of the ORIGINAL itemised invoices, receipts and supporting medical information (medical report, referral letter and discharge report) to process your claim. (Please retain your ORIGINAL documents as we may request these at a later date.)
- For Worldwide claims excluding Far East Email: claims@healthcareinternational.com Telephone: +44 (0)20 7590 8800
- For Far East Claims from the following countries: Cambodia, China, Hong Kong, Indonesia, Japan, Laos, Malaysia, Myanmar, Philippines, Singapore, South Korea, Thailand, Timor-Leste, Vietnam Email: hci@euro-center.com Telephone: +66 2 569 0118

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4) Date of birth (dd/mm/yyyy): 5) Policy/ID number: 6) Group name (if applicable): 7) Telephone number: 8) Email address: 9) Full mailling address: (include town and country) 10) Do you have any other insurance which may provide cover? YES NO 11) Is this claim a result of an accident? YES NO 12) Please describe the medical symptoms/condition you wish to claim for: 13) Is this the first time you have experienced these symptoms? YES NO 14) How long did you have symptoms before consulting with a doctor? 15) When did you first see a doctor/specialist for these symptoms? B. List and Description of Medical Expenses (please attach originals for all listed expenses) Date of Treatment Invoice Date Invoice Reference Currency and Amount Company of the provided of t	3) First name(s):		1) Title: Mr Mrs
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HCI/MD/Claim_Form/13.08

(Relationship if signed by other than claimant):

Declaration: I hereby certify that the information provided is correct and true to the best of my knowledge. I also acknowledge that if this claim relates to a pre-existing condition that has not been accepted by the insurer in writing, it may not be approved for payment. I understand in the event of this claim being misleading or fraudulent, in

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company, other person or firm to provide HealthCare International or their authorised representative information, including copies of records, concerning advice, or treatment provided to me and/or my dependents,

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



If YES, please provide known details: What treatment was administered? What medication is the patient currently taking/prescribed? What diagnostic tests or investigations are planned or have taken place? If YES, please detail what and include the dates: Have you referred the patient to another specialist? YES NO If YES, what date did you refer them and please provide contact details of the specialist: Provider Contact Details (to be completed by your treating doctor/specialist, in BLOCK CAPITALS)) When did the patient first register with you/the clinic/hospir	tal? Date (dd/mm/yyyy):
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