+44 (0)20 7590 8800
claims@healthcareinternational.com
healthcareinternational.com

Medical Treatment Guarantee Request Form

Important Information - please read carefully

- **This form must be fully completed in BLOCK CAPITALS and received by HealthCare International at least five (5) working days prior to planned treatment.**
- **Our member must fully complete and sign page one. The medical provider must fully complete and sign page two.**
- **Failure to fully complete this form will delay our ability to guarantee the eligible treatment costs.**
- **Any Guarantee of Payment is subject to the Terms and Conditions of the insurance policy and is subject to the policy being in force at the time of treatment.**
- **Any Guarantee of Payment is subject to medical assessment of all relevant medical information by HealthCare International in respect of this medical condition.**
- **If additional treatment is required, HealthCare International must be notified.**

For Worldwide Excluding Far East Claims & Emergency Assistance contact:

HealthCare International, UK Claims Office, 48 Berkeley Square, London, W1J 5AX United Kingdom.

T: +44 (0)20 7590 8816
F: +44 (0)20 7590 8819
E: claims@healthcareinternational.com

For Far East Claims & Emergency Assistance in the following countries:
Cambodia, China, Hong Kong, Indonesia, Japan, Laos, Malaysia, Myanmar, Philippines, Singapore, South Korea, Thailand, Timor-Leste, Vietnam, contact:

Euro-Center (Thailand) Co., Ltd.
Evergreen Place, 10th Floor 318 Phayathai Road,
Ratchathewi, Bangkok 10400, TH.
T: +66 2 569 0118
E: HCI@euro-center.com

A. Claimant Details

1) Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: .....

2) Family name (surname): ..... 3) First name(s): .....

4) Date of birth (dd/mm/yyyy): ..... 5) Policy/ID number: .....

6) Group name (if applicable): ..... 7) Full mailing address (include town and country): .....

.....

8) Email address: ..... 9) Telephone number: .....

B. Medical Provider Contact Details

1) **Name of Hospital/Clinic:** ..... Address: .....

.....

Email address: .....

Telephone number: ..... Fax number: .....

2) **Name of treating Doctor:** ..... Doctor address: .....

.....

Email address: .....

Telephone number: ..... Fax number: .....

3) **Name of referring Doctor:**..... Telephone number:.....

Email address: .....

C. Claimant Signature and 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 whole or part, the claim may be rejected and the policy may be invalidated.

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, 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, 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 the right to receive a copy of this authorisation.

Signature: ..... (Relationship if signed by other than claimant): ..... Date: .....

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

D. Medical Information (to be completed by the treating doctor/specialist, in **BLOCK CAPITALS**)

1) When did the patient first notice symptoms of this condition? Date (dd/mm/yyyy): .....

2) What date did the patient first present these symptoms? Date (dd/mm/yyyy): .....

3) Please provide a description of the symptoms: .....

.....

.....

4) What (if any) diagnostic tests, investigations or conservative treatment has taken place?.....

.....

5) What is the current diagnosis (include ICD Code)?.....

.....

6) Is this condition as a result of an accident? ☐ YES ☐ NO If YES, please provide known details: .....

.....

7) What is the treatment plan, please list all planned procedures, treatment and tests: .....

.....

8) Planned treatment date? Date (dd/mm/yyyy): .....

9) Estimated length of stay: .....

10) Please provide details of the prognosis based on the current proposed course of treatment: .....

.....

11) Are further treatments or consultations planned? ☐ YES ☐ NO

If YES, please detail what and include the proposed dates: .....

.....

12) Have you referred the patient to another specialist? ☐ YES ☐ NO

If YES, please provide contact details of the specialist:.....

.....

13) Further medical information (If applicable):.....

.....

E. Total Claim Costs:

1) **Total estimated costs for this treatment:**

Currency: ..... Consultant costs: .....

Anaesthetist costs: ..... Hospital costs: .....

Other costs: .....

F. Declaration by Doctor:

I declare that I am the patient's treating doctor and that the particulars given are, to the best of my knowledge, full, true and complete.

Please sign and authenticate with an official stamp.

Provider stamp

Signature of doctor: ..... Date: .....

PLEASE COMPLETE IN BLOCK LETTERS

HCI/MD/TGF/13.09

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