



## OUTPATIENT MEDICAL INSURANCE CLAIM FORM

The insured member is required to complete the following claim form and attach all the original medical bills when filing the claim. A separate claim form must be completed for each medical condition, each currency and each member.

### SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Insured Member	Policy No.	Occupation	Marital Status	Date of Birth	Sex
_____	_____	_____	_____	_____	_____
Name of Patient (If other than the Insured Member)	Passport/ID No.	Occupation	Marital Status	Date of Birth	Sex
_____	_____	_____	_____	_____	_____
Present Home Address	Contact Telephone No.	Email Address			
_____	_____	_____			

### SECTION B: CLAIM DETAILS

Description of medical condition. If due to an accident, please describe nature of injury.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total amount claimed (including currency) \_\_\_\_\_

### SECTION C: SETTLEMENT DETAILS

Provided your claim is eligible, we will send a cheque in settlement to the address above.

Electronic Fund Transfer – only available if the payment is more than US \$500.

(Please note that bank charges are likely to apply)

Please provide bank details:

Name of Account Holder: \_\_\_\_\_ Name of Beneficiary Bank & Branch: \_\_\_\_\_

Beneficiary Bank Account No: \_\_\_\_\_ Address of Bank & Branch: \_\_\_\_\_

SWIFT Address / Clearing Code (if applicable): \_\_\_\_\_

NOTE: Payment shall not include clinic, physician and any other medical providers.

**DECLARATION & AUTHORISATION** (This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)

I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Insured Member

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



**SECTION D: TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON**

Note: If there are multiple doctors, this section is to be completed by the last attending physician.

Name of Patient: \_\_\_\_\_

Passport/ID No: \_\_\_\_\_

1. Final Diagnosis (BLOCK CAPITALS PLEASE)

ICD Code:

DRG Code:

2. Other Diagnosis (BLOCK CAPITALS PLEASE)

ICD Code:

DRG Code:

3. When did the patient first consult you for this condition?  
\_\_\_\_\_

4. Please specify the approximate date of discovery of the illness or injury:  
\_\_\_\_\_

5. How long has the illness/injury been existing prior to consulting you?  
\_\_\_\_\_

6. Nature of Treatment: \_\_\_\_\_

7. Date of Treatment rendered: \_\_\_\_\_

8. Doctors previously consulted by the patient for the above condition:

Name	Approximate Date	Name of Clinic	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Physician/Surgeon: \_\_\_\_\_

Name of Physician/Surgeon: \_\_\_\_\_

Name and Address of Clinic/Hospital: \_\_\_\_\_

Name and Address of Clinic/Hospital: \_\_\_\_\_

Date: \_\_\_\_\_