# CLAIM FORM

**Call:** + 44 (0) 20 7590 8800 **Member Portal:** https://members.hcigroupglobal.com/
**Website:** hcigroupglobal.com **Email:** claims@healthcareinternational.com

## IMPORTANT INFORMATION

- This form can be sent to us via the Member Portal or via email
- A separate form should be completed for each claimant and each event/condition.
- 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.)

## CLAIMANT DETAILS

| | |
|---|---|
| **Name** | |
| **Policy Number** | |
| **E-Mail** | |
| **Telephone Number** | |

**Do you have any other insurance which may provide cover?** ☐ YES ☐ NO

**Is this claim a result of an accident?** ☐ YES ☐ NO

**Please describe the medical condition/symptoms you wish to claim for**

**Is this the first time you have experienced these symptoms?** ☐ YES ☐ NO

**How long did you have symptoms before consulting with a doctor?**

**When did you first see a doctor/specialist for these symptoms?**

## DESCRIPTION OF MEDICAL EXPENSES

Please attach original copies of your invoices and proof of payment for all listed expenses.

| **Date of Treatment** | **Treatment Description** | **Treatment Provider** | **Amount Claimed** (invoice currency) | **Reimbursement currency** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | **TOTAL** | | |

## PAYMENT DETAILS

**Who would you like us to pay?** **Doctor/Provider** **Claimant** (pay you directly) **Group** (if on a company plan)

**Bank transfer details:**

**Account holder name**

**Bank name and address**

(include town and country)

**SWIFT/BIC Code**

**Account number / IBAN**

**Sort code / routing number**

## 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 could lead to the policy being 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** **Date**

**Relationship if signed by someone other than the claimant**

## MEDICAL INFORMATION (TO BE COMPLETED BY THE TREATING DOCTOR)

**When did the patient first register with you / the clinic / hospital?**

D D M M Y Y

**What date did the patient first present these symptoms?**

D D M M Y Y

**When did the patient first notice signs or symptoms of this condition?**

D D M M Y Y

**Please provide a description of the symptoms**

**What is the current diagnosis including ICD code?**

**Is this claim a result of an accident?** YES NO

if yes, please provide details

**What treatment has been administered?**

**What medication is the patient currently taking / prescribed?**

**What diagnostic tests or investigations are planned or have taken place?**

**Are further treatments or consultations planned?** YES NO

if yes, please provide details and include dates

**Have you referred the patient to another specialist?** YES NO

if yes, please provide contact details of the specialist and dates

## PROVIDER CONTACT DETAILS

| | |
|---|---|
| **Name** | |
| **Qualifications** | |
| **Name of hospital/clinic** | |
| **Telephone Number** | |
| **Email address** | |
| **Address** | |

## PROVIDER DECLARATION

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.

**Signature** **Date**