PREMIER INTERNATIONAL HEALTHCARE GLOBAL

MEDICAL CLAIM FORM

Claims Reference Number (if known):

Important Notes

- To assist us in processing your claim efficiently and speedily, please complete this form fully, clearly and legibly.
- Please complete Sections A, B, C and D.
- The attending doctor should complete Section E.
- All claims should be submitted within 60 days of start of treatment.
- Please attach all originals bills, retaining photocopies for your reference
- A separate claim form should be used for each patient and each medical condition.
- Processing of your claim may be delayed if the information provided is incomplete.

SECTION A : PATIENT DETAILS

Title			Surname			
Sex	M	F	First Name			
Policy Number					Date of Birth	D D M M Y Y Y Y
Address						
Town/ City				Country		
Postcode				Email		
Work Contact (Tel)				Home Contact (Tel)		

SECTION B : DETAILS OF ILLNESS / INJURY

Please describe the nature of your illness / injury:

Date of First Symptoms	D	D	M	M	Y	Y	Y	Y

Date of First Medical Consultation	D	D	M	M	Y	Y	Y	Y

If your injury or illness has resulted from an accident, please provide details of the circumstances along with names, addresses and telephone numbers of any third parties and witnesses involved:
If the accident was reported to the police please provide the report date, the report number and the police station details:

Is this a continuation of a previous claim? If Yes, please provide details: Yes ☐ No ☐

Do you have any other insurance which covers the same incident? If Yes, please provide details: Yes ☐ No ☐

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(continued)

Please Confirm Details of your Family Doctor			
Name			
Address			
Telephone No.		Fax No.	

Section C : Details of Expenses Incurred

Please give details of accounts included with this claim:

Date	Nature of Expense	Amount Paid	To whom should settlement be made and in which currency?

If you provide your bank details below once approved we will settle the claim by direct bank transfer.
If you leave this blank we will settle the claim by cheque.

Name of Bank	
Address of Bank	
Country of Bank	
Name of Account Holder	
Account Number	
Bank Sort/ Swift Code	
IBAN (International Bank Account No)	

Section D : Declaration

I/We confirm the facts stated on this form to be true and accurate to the best of my / our knowledge. I /We give authority to the insurers or their representatives to contact my/our Medical practitioners for any additional information required in connection with this claim.

Signed	Date

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(continued)

SECTION E : TO BE COMPLETED BY THE ATTENDING DOCTOR

Please indicate the date on which the patient first consulted you for this illness and/or any other related illness:

Details of any referring doctor:

Diagnosis and ICD 9 code applicable:

Do you believe the patient has had treatment for this or any previous related illness? If Yes, please specify: Yes ☐ No ☐

In the event of maternity claims, please specify

Estimated Date of Delivery D D M M Y Y Y Y

Date of last Menstrual Period: D D M M Y Y Y Y

Name:

Address:

Signature:

Date:

Hospital / Practice Stamp