

# InterGlobal HealthCare Plans

## Medical Claim Form

For medical treatment reimbursements

Please complete clearly in **BLOCK CAPITALS**.

Please note that claims payment may be delayed if all sections of the form are not completed in full. The form must be returned to us within six (6) months of the initial treatment date. Always enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable.

### A Member Details - to be completed by member/patient only

If the patient is a dependant under the age of 18, the member is required to complete sections B to E.

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:	
Family Name:	First Names:	
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Group Name (if applicable):	Member Number:	
Personal Address:		
Town:	City:	
Postal Code:	Country:	
Telephone:	Fax:	Email:

### B Patient Details

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:	
Family Name:	First Names:	
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Symptoms/Conditions requiring visit:

### C Further Information

Do you (or the patient) have another insurance policy that covers these medical costs?  Yes  No

If yes, please complete the following details

Name of Insurer:	Policy Number:
Address of Insurer (if known):	

Is this claim the result of an accident, which was the fault of another person/party?  Yes  No

If yes, please provide details of the Solicitor/Lawyer/Legal Counsel acting on your behalf

Name of Solicitor/Lawyer/Legal Counsel:
Address:

Have you previously submitted a claim for this medical condition under a previous insurance policy or under your current insurance plan with us?

Yes  No  If yes, please provide details:



## H Medical information

28 December 2005

This section is to be completed by the Medical Practitioner/Specialist/Consultant/Therapist

1. Name of Medical Practitioner/Specialist/Consultant/Therapist:		Qualifications:	
Telephone Number:		Fax Number:	
2. Has the patient been referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details:			
Name of referring practitioner:		Qualifications:	
Address:			
Telephone Number:		Fax Number:	
3. On what date did the patient first present these symptoms to you? Date (dd/mm/yy):			
Prior to consulting you, when did the patient first notice signs and symptoms of this medical condition?		Date (dd/mm/yy):	
Please provide full details of the medical condition requiring treatment:			
Has the patient suffered from the same or similar symptoms previously? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details of previous episodes, including dates:			
4. Investigations required <input type="checkbox"/> LAB <input type="checkbox"/> Radiology <input type="checkbox"/> Other			
Please provide details:			
5. Applicable to dental treatment only			
Was the patient suffering from dental pain at the time he/she visited you for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Was the dental treatment considered? <input type="checkbox"/> Routine <input type="checkbox"/> Emergency			
6. Diagnosis of the medical condition if known at present:			
Treatment proposed:	Rx:	Rx:	Rx:
Is a follow up visit required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please confirm when (dd/mm/yy):		
7. If physiotherapy is the appropriate treatment for this condition, please state how many sessions will be required: <input type="text"/>			
8. Please advise admission and discharge dates (if applicable):			
9. In your opinion, would you consider the medical condition to be?			
<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Acute episode of a chronic condition			
10. In your opinion, is the treatment for cosmetic reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Name of Specialist/Consultant, including qualifications, to whom patient has been referred:			
Date of referral:			
12. I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.			
Medical Practitioner's/Specialist's/Consultant's/Therapist's Signature:		Date (dd/mm/yy):	

## No Claims Discount

### Applies to Individual Plans only and not Group Plans

PLEASE NOTE: By making this claim, you will affect your no claims discount.

## Excess

If you have an excess on your plan, please remember that a deduction will be made against any reimbursement issued.

## Checklist

Have you enclosed:	Tick
• Original itemised invoices (copies will not be accepted)	<input type="checkbox"/>
• Original admission and discharge form if claiming the Hospital Cash benefit	<input type="checkbox"/>
• Have you completed this form in full?	<input type="checkbox"/>

## Send your claim to:

InterGlobal Healthcare  
 IAG Insurance (Thailand) Ltd  
 24th Fl, Thanapoom Tower,  
 1550 New Petchburi Road,  
 Makkasan, Ratchtevi, Bangkok 10400  
 Thailand  
 Tel: +66 (2) 207 0266  
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