GLOBAL EXPATRIATE HEALTHCARE

Claim Form

Claims Reference Number (if known)	

Important Notes

- To assist us in processing this claim efficiently and speedily, please complete this form fully, clearly and legibly.
- Please complete this form in English
- 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 Original Relevant Bills including the itemised cost breakdown, Medical Certificates, Lab Test Results, and all other Medical Reports.
- A separate claim form should be used for each patient and each medical condition.
- Processing of this claim may be delayed if the information provided is incomplete.

SECTION A – Patient Details

Policy Holder	
Policy Number	
Claimant's Title	Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Other:
Forename(s)	
Surname/Family Name	
Date of Birth	D D / M M / Y Y Y Y
Address	
Postcode (if applicable)	
Country	
Daytime Telephone	
Evening Telephone	
E-mail	

SECTION B - Details of Illness / Injury

Please describe the nature of your illness / injury:

Date of First Symptoms :

D	D	/	M	M	/	Y	Y

Date of First Medical Consultation

D	D	/	M	M	/	Y	Y

If your injury 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? Yes ❑ No ❑

If Yes, please provide details:

Do you have any other insurance which covers the same incident? Yes ❑ No ❑

If Yes, please provide details:

Please Provide Details of your Family Doctor:

Name			
Address			
Telephone No		Fax No	

SECTION C - Details of Expenses Incurred

Please provide the following details:

Date of Service	D	D	/	M	M	/	Y	Y	Y	Y

Place of Service	
Name of Provider	
Full Details of Treatment Given	
Type of Service	
Diagnosis	

Charges Incurred		Currency	

Please provide your bank details below once approved will settle the claim by direct bank transfer.

Name of Bank:	
Address 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:	
Print Name:	

Date:	D	D	/	M	M	/	Y	Y	Y	Y

SECTION E - To be completed by the treating doctor

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

Date:	D	D	/	M	M	/	Y	Y	Y	Y

Diagnosis and ICD 10 code applicable:

In your opinion has the patient previous had treatment for this or any related illness? Yes ❑ No ❑

If Yes, please specify:

In the event of this being a maternity claims please specify:

Estimated Date of Delivery:

D	D	/	M	M	/	Y	Y

Date of Last Menstrual Period:

D	D	/	M	M	/	Y	Y

Details of treating Doctor

Name	
Address	
Signature	
Date	D D / M M / Y Y

Hospital/Practice Stamp

Please return this form to your Broker / Intermediary, or

Email to : LAMP@euro-center.com