

InterGlobal HealthCare Plans



International Private Medical Insurance

Claim Form for Medical Treatment Reimbursements

Please complete clearly in block capitals. Information about how to complete can be found on the reverse of this form.

Please call us on +44 (0) 1252 745 945 or email claims@interglobalpmi.com if you require any further assistance.

A Patient details

If the patient is a dependant under the age of 18, the main member must complete sections A to G for the patient.

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Group name (if applicable):	
Member number:	Plan number:
Correspondence address:	
Town:	Postal code:
Country:	Email:
Daytime telephone:	Fax:
Evening telephone:	

Symptoms/condition needing treatment:

B Main member details (if different from section A Patient details, above)

Family name:	First name(s):
Member number:	Plan number:

C Further information

Does the patient have another insurance policy that covers medical costs?

 Yes

 No

If yes, please provide details on a separate sheet.

If you have suffered an injury as the result of an accident, are you claiming from a third party?

 Yes

 No

If yes, please provide details on a separate sheet.

Is your claim as a result of an accident?

 Yes

 No

If yes, please provide the circumstances of the accident and how it happened on a separate sheet.

D Hospital cash benefit

Are you claiming hospital cash benefit?

 Yes

 No

If yes:

- Please make sure that your attending medical practitioner, specialist or consultant provides the dates of admission and discharge in section H
- Please send us the original admission and discharge form from the hospital where the treatment was provided

E Payment details

Have you personally had to pay costs for the treatment that you are claiming for?

 Yes

 No

If yes, and you are personally seeking reimbursement, please tell us how you wish to be reimbursed (please tick one):

<input type="checkbox"/> 1. Bank transfer. Please complete this information for bank transfer payments (please note that this is the quickest and safest method of payment):	
Name of your bank:	Account number:
Address of your bank:	
Name of account holder:	BIC (swift code):
Bank sort code (if applicable):	IBAN (if applicable):
Currency of bank account:	Routing code (if applicable):
<input type="checkbox"/> 2. Foreign draft. Please specify currency:	
<input type="checkbox"/> 3. Cheque in the currency of your plan.	

F Claim details

Date of treatment	Invoice date	Invoice reference	Amount (including currency)

G Signed declaration

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by the insurer or authorised administrator. I confirm and agree that any personal information collected or held by the insurer or authorised administrator, whether given in this form or collected in any other way, may be used by the insurer or authorised administrator, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving ongoing insurance cover, customer service and the processing of future claims, ii) processing and making payments, and iii) within the limits of relevant consents, providing marketing communications in respect of the insurer, its related products and services and those of its associated companies.

G Signed declaration (continued)

I understand that InterGlobal Insurance Company Limited may use organisations who may be located in the EEA or elsewhere. Where an organisation is located outside the EEA, InterGlobal Insurance Company Limited will take all necessary steps to ensure the organisation provides appropriate guarantees in respect of their technical and organisational security measures and the transfer and processing complies with all relevant data protection and privacy laws. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for InterGlobal Insurance Company Limited to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members. Our full terms and conditions and details of our privacy policy can be found at www.interglobalpmi.com

Patient's/member's signature:

Date (dd/mm/yy):

H Medical information (except dental)

This section must be completed by the medical practitioner/specialist/consultant/therapist.

Note to the medical practitioner/specialist/consultant/therapist: Please give this form back to the patient after you have completed. For dental treatment, please use section I (over the page).

Practice stamp:

1. Contact details

Name of medical practitioner/specialist/consultant/therapist:

Qualifications:

Telephone number:

Fax number:

2. Registration details

How long has the patient been registered with you/the clinic/the hospital?

Please provide dates (dd/mm/yy):

3. Referrals

a) Was the patient referred to you? Yes No

Name of referring practitioner:

Qualifications:

Address:

Telephone number:

Fax number:

Date of referral (dd/mm/yy):

Email:

b) Have you referred the patient? Yes No

Name of specialist/consultant to whom you referred the patient:

Date of referral (dd/mm/yy):

If available, please provide a copy of the referral letter

4. Symptoms

a) Has the patient suffered from the same or similar symptoms before? Yes No

If yes, please provide dates:

b) On what date did the patient first notice these symptoms (dd/mm/yy)?

c) On what date did the patient first present these symptoms to you (dd/mm/yy)?

d) Please provide full details of the symptoms needing treatment:

5. Diagnosis

Diagnosis of medical condition, if known:

ICD10 code:

What is the underlying cause of the condition:

Was the medical condition as a result of an accident? Yes No

Was the member under the influence of alcohol, drug or any other intoxication substance at the time of the accident? Yes No

Treatment proposed:

Is a follow-up visit needed? Yes No

If yes, when (dd/mm/yy)?

6. Investigations requested

Please provide details:

7. Type of condition

In your opinion, is this condition: Acute? Chronic? Acute episode of a chronic condition?

8. Type of complementary treatment recommended (if relevant):

Physiotherapy Osteopathic Chiropractic Homeopathic Acupuncture Chinese medicine

Number of sessions needed: **9. Hospital admission**

Has the patient been admitted to hospital for this condition? Yes No

If yes, please provide admission date (dd/mm/yy):

And discharge date (dd/mm/yy):

H Medical information (except dental) (continued)

10. Cosmetic treatment

In your opinion, is the treatment for cosmetic reasons? Yes No

11. Maternity treatment

Is the pregnancy a result of infertility treatment/medication, including conception by artificial means? Yes No

If yes, please provide method of conception:

12. Declaration

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):

Title: Mr Mrs Miss Ms Other:

Family name: First name(s):

Date of birth (dd/mm/yy):

I Dental treatment

This section must be completed by the dental practitioner.

Note to the dental practitioner: Please give this form back to the patient after you have completed it.

Practice stamp:

1. Contact details

Name of dental practitioner:

Qualifications:

Telephone number: Fax number:

Email:

2. Registration details

How long has the patient been registered with you/the clinic/the hospital?

Please provide dates (dd/mm/yy):

3. Symptoms

- a) Was the patient suffering from dental pain when they first visited you? Yes No
 b) Has the patient suffered from the same or similar symptoms before? Yes No

If yes, please provide dates:

c) On what date did the patient first notice these symptoms (dd/mm/yy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yy)?

e) Please provide full details of the symptoms needing treatment:

4. Treatment

- a) In your opinion, was the dental treatment: Routine? Emergency?
 b) Please complete the dental chart by using the abbreviations below:

Dental chart																		
	Right								Left									
Treatment																		
Finding																		
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw	
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw	
Finding																		
Treatment																		

Finding:

b = bridge
 c = crown
 ca/da/dn = caries/decay/dental necrosis
 cl = calculus
 g = gap closure
 gb = gingival bleeding
 gi = gingivitis

gs = gingival swelling
 i = implant
 in = inlay
 m = missing tooth
 p = periodontis
 pu/od = pulpitis or odontitis

Treatment:

AF = amalgam filling
 CF = composite filling
 D = denture
 E = extraction
 I = implant
 IN = inlay

M = metal ceramic crown
 NB = new bridge
 NC = new crown
 O = orthodontics
 ON = onlay
 OR = oral radiograph

PR = panoramic radiograph
 RB = replacement bridge
 RC = replacement crown
 RCT = root canal treatment
 S&P = scale and polish

If the treatment was NC or RC, was a precious or semi-precious metal used? No Yes If yes, what?
 If the treatment was IN or ON, was a precious or semi-precious metal used? No Yes If yes, what?

I Dental treatment (continued)**5. Breakdown of costs**

Invoice reference	Treatment (itemised)	Amount (including currency)

6. Declaration

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Dental practitioner's signature:	
Date (dd/mm/yy):	
Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	

Important information

Please remember these important points when completing your claim form:

- Assessment of your claim may be delayed if you and your medical or dental practitioner do not complete all the necessary sections of this form.
- Complete one form per medical condition, per person.
- Return this form to us within six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.
- Make sure that you complete sections A to G and that all doctors who have treated you complete section H (or section I for dental treatment).

Section A – Patient details

- If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the patient is under 18 and has their own plan, a parent or legal guardian must complete the form and sign the declaration for them.

Section C – Further information

- If you have another insurance policy that covers you for medical costs, we will need to know the details as it may affect the amount we pay in respect of your claim. Please give the name of the insurance company, the name of the plan holder, the plan and/or member numbers on a separate sheet of paper and submit it to us with your claim form.

Section D – Hospital cash benefit

- You can claim hospital cash benefit if you have stayed overnight in hospital and the hospital has not charged you or any other party for treatment. Please see your plan guide and table of benefits for more information on hospital cash benefits.

Section E – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider direct, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

- Please ensure that you are able to receive payment in the method and currency you have requested. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment or raising a new one.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
- If you do not give us the IBAN or BIC, you may incur bank charges.
- Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies. In the event that we are unable to make payment in the currency you have specified, we will contact you to confirm an alternative currency.

We cannot make payment in the following currencies:

- Chinese Yuan Renminbi (RMB)
- Brunei Dollars (BND)
- Venezuelan Bolivares (VEB)
- Zimbabwean Dollars (ZWD)
- Lebanese Pounds (LBP)

If you do not specify a payment currency, we will pay your claim in the currency of your plan.

- Please note we cannot make claim reimbursement payments via foreign draft or cheque to banks based in Qatar.

Sections G, H and I

If the declaration has not been read and signed, we will not be able to process your claim.

No claims discount

Applies to individual and family 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, this will be deducted from any reimbursement.

Checklist

Have you sent us:

- A fully completed claim form with signed and dated declaration?
- Original itemised invoices (copies will not be accepted)?
- Original hospital admission and discharge form if claiming hospital cash benefit?

**Send your claim to: Claims Team, InterGlobal Limited, Woolmead House East, The Woolmead, Farnham, Surrey GU9 7TT, United Kingdom
F +44 (0) 1252 745 921 W www.interglobalpmi.com**

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