1 January 2007

InterGlobal
Innovations in International Private Medical Insurance

InterGlobal HealthCare Plans

Medical Claim Form

For medical treatment reimbursements

Please complete clearly in block capitals. Please call us on +44 (0) 1252 745 945 or email claims@interglobalpmi.com if you need any help filling in this form.

Please remember these important points about filling in your claim form:

- Assessment of your claims may be delayed if you and your medical or dental practitioner do not fill in all the necessary sections of this form.
- Fill in one form per medical condition.
- 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 fill in sections A to G and that all doctors who have treated you fill in section H (or section I for dental treatment).

A Patient details

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

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	Sex: ☐ Male ☐ Female
Group name (if applicable):	
Member number:	Plan number:
Correspondence address:	
Town:	Postal code:
Country:	E-mail:
Telephone:	Fax:

Symptoms/condition needing treatment:

B Main member details

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 give details 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 gives 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 given

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):

☐ 1. Bank transfer. Please fill in this information for bank transfer payments:

Name of your bank:	Account number:
Address of your bank:	
Name of account holder:	BIC number:
Bank sort code:	IBAN number:
Currency of bank account:	Routing code/swift code:

☐ 2. Foreign draft. Please tell us what currency:

☐ 3. Cheque in GB pounds (£)

Please note:

i) If you do not give us the IBAN or BIC number, you may have to pay bank charges.

ii) We cannot pay bank transfers or foreign drafts in the following currencies:
- RMB (China Yuan Renminbi) - CNY
- Brunei dollars - BND
- Malaysia ringgitts - MYR
- Venezuala bolivares - VEB
- Zimbabwe dollars - ZWD
- Lebanon pounds - LBP

iii) If you receive a claim payment and then decide that you would like the payment in a different currency or payment method from the one that you choose on this form, we reserve the right to pass on to you any payment charges incurred by us for cancelling the original payment or raising a new one.

iv) We will not be responsible for any payment shortfall due to exchange rate fluctuations.

v) If you do not specify a currency above, we will pay your claim in the currency of the invoices that you have sent us unless that currency is one of those listed in point ii. In that case, we will pay your claim 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 under English Law. 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 InterGlobal Limited.

I confirm and agree that any personal information collected or held by InterGlobal, whether given on this form or collected in any other way, may be used by InterGlobal, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving on-going insurance cover, customer service and the processing of future claims, ii) processing and making payments, iii) providing marketing communications in respect of InterGlobal, its related products and services and those of its associated companies.

Patient's/member's signature:	Date (dd/mm/yy):

H Medical information (except dental)

Practice stamp:

This section must be filled in 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 filled it in. For dental treament, please use section I (over the page).

1. Contact details

Name of medical practitioner/specialist/consultant/therapist:	
Qualifications:	
Telephone number:	Fax number:

2. Referrals

a) Was the patient referred to you? ☐ Yes ☐ No

Name of referring practitioner:	Qualifications:
Address:	
Telephone number:	Fax number:

b) Have you referred the patient? ☐ Yes ☐ No

Name of specialist/consultant to whom you referred the patient:	
Qualifications:	Date of referral (dd/mm/yy):

3. Symptoms

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

If yes, please give 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 give full details of the symptoms needing treatment:

4. Investigations requested

Please give details:

5. Diagnosis

Diagnosis of medical condition, if known:	ICD10 code:
Treatment proposed:	
Is a follow-up visit needed? ☐ Yes ☐ No	If yes, when (dd/mm/yy)?

6. Type of condition

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

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

a) Physiotherapy	☐	Number of sessions needed:	☐
b) Osteopathic treatment	☐	Number of sessions needed:	☐
c) Chiropractic treatment	☐	Number of sessions needed:	☐
d) Homeopathic treatment	☐	Number of sessions needed:	☐
e) Acupuncture	☐	Number of sessions needed:	☐
f) Chinese medicine	☐	Number of sessions needed:	☐

8. Hospital admission

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

If yes, please give admission date (dd/mm/yy):	And discharge date (dd/mm/yy):

9. Cosmetic treatment

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

10. 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):

I Dental treatment

Practice stamp:

This section must be filled in by the dental practitioner.

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

1. Contact details

Name of dental practitioner:	
Qualifications:	
Telephone number:	Fax number:

2. 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 give 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 give full details of the symptoms needing treatment:

3. Treatment

a) In your opinion, was the dental treatment: ☐ Routine? ☐ Emergency?

b) Please fill in the dental chart by using the abbreviations below:

Dental chart

	Right								Left								
Treatment																	Treatment
Finding																	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																	Finding
Treatment																	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? ____

4. 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):

Important information

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 filled in 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:

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