Treatment Guarantee Request Form

Important Information - Please read carefully

Complete all relevant information in BLOCK CAPITALS and tick the relevant boxes.

To help us process the direct settlement of your medical expenses in a timely manner, please follow the guidelines below. If you have any questions, please contact our Helpline.

To the insured member/patient.
In order to ensure swift guarantee of your treatment, please ensure that you complete sections 1 and 2. Please also ensure that your doctor completes all questions in sections 3.

Failure to complete this form will delay our ability to guarantee your treatment with the medical provider, as we may have to revert to you or the medical provider for further information.

The insured member's policy must be in force at the time of treatment.

Please be advised that Guarantee of Payment is subject to the Terms and Conditions of the insurance policy as agreed between HealthCare International and the insured member, and also subject to medical assessment of all relevant medical documentation received, or yet to be received, by HealthCare International in respect of this medical condition.

HealthCare International, UK Claims Administration Office, 95 Cromwell Road, London, SW7 4DL, United Kingdom
Helpline: +44 (0)20 7590 8816
Fax: +44 (0)20 7590 8819
Email: claims@healthcareinternational.com

If you are not completely satisfied with the level of service received or the outcome of a claim from HealthCare International then please contact our Customer Care Team by email, customercare@healthcareinternational.com or telephone +44 (0)207 590 8801. They will be happy to discuss this with you.

1. Insured Section

To be fully completed by the insured member/patient.

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Other: _____

First Name: _____ Family Name: _____

Policy Number: _____ E-mail: _____

Telephone No.: _____ Fax No.: _____

2. Patient Signature and Release of Medical Records

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company, or other person or firm to provide HealthCare International or their authorised representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to all medical and mental illness or use of drugs or alcohol.

If a minor was treated, a patient or guardian should sign this section.

Patient's Signature : _____ Date: _____

To the medical provider.
Please note that the patient is insured by HealthCare International. We guarantee (subject to approval) payment of the expenses specified in this Treatment Guarantee Form in accordance with the following conditions:

- If additional treatment is required, HealthCare International must be notified.
- The hospital should submit this Treatment Guarantee Form and the corresponding invoices to HealthCare International within 30 days of patient discharge.
- HealthCare International will settle the guaranteed expenses within 5 days of receipt.
- If invoices are received more than 60 days after patient discharge, acceptance of liability for those expenses remains at the discretion of HealthCare International.

3. Medical Certificate (To be fully completed by medical provider.)

For In-patient Treatment:

Estimated Cost (incl currency): _____

Planned Admission Date: _____

Estimated Length of Stay: _____

Hospital/Facility Name: _____

Address: _____

_____

Email Address: _____

Telephone Number: _____

Fax: _____

Date of first attendance for this condition? _____

Name and telephone number of referring doctor:

Date of Referral: _____

Name: _____

Telephone Number: _____

How long prior to this date would condition or symptoms been apparent to the patient? _____

Date present condition first diagnosed? _____

Name of the Attending/Admitting Physician: _____

Admission Type: ☐ In-patient ☐ Out-patient ☐ Dental

Diagnosis (ICD-10 or any other code if available, otherwise a full description): _____

_____

_____

Planned Procedure with Medical Justification: _____

_____

_____

Please provide details of your prognosis based on the proposed course of treatment: _____

_____

_____

Pregnancy

Date pregnancy confirmed by doctor: _____

Is single pregnancy expected? ☐ Yes ☐ No

Expected or actual date of delivery: _____

If no, is pregnancy a result of infertility treatment, including conception by artificial means, other than artificial insemination? ☐ Yes ☐ No

Please sign and authenticate with an official stamp.

Doctor's stamp

Signature of Doctor: _____ Date: _____

The confidentiality of patient and member information is of paramount concern to HealthCare International. HealthCare International fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have the right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

Please Send Application Form To The HealthCare International Claims Administration Office

HealthCare International
HCI 24:7 Claims Administration Office

Tel: +44 (0)20 7590 8800 Fax: +44 (0)20 7590 8815
claims@healthcareinternational.com www.healthcareinternational.com

95 Cromwell Road, London, SW7 4DL
United Kingdom