

Claim form

Duly completed claim form enables smoother claims reimbursement!

Section A + B: to be completed for outpatient claims with no follow-up treatment/visit; dental, maternity, and optical claims

Section A + B + C: to be completed for hospitalization and outpatient claims that requires follow up visits

Before submitting your claim, kindly ensure that all supporting documents are included along with the duly completed claim form (where applicable):

- Original invoices and receipt of payments
- Medical report/Discharge summary for inpatient/day care claim
- Medical prescription for pharmacy, laboratory, radiology, optical expenses, and series of treatments
- Medical report for laboratory and radiology

Section A – To be completed by policyholder (or parent/guardian if a minor)

Insured member's information

Last Name:

First name:

ID/Index Number (indicated on your card):

Client Services Team (indicated on your card):

E-mail:

Phone (including country code):

Country of assignment:

Patient's information

Last Name:

First name:

Date of Birth (mm/dd/yyyy):

Country of care:

Section B – To be completed by policyholder (or parent/guardian if a minor)

Claim information

Type of service: Outpatient Maternity Dental Vision Date of service (mm/dd/yyyy):

Incurred Currency:

Incurred amount:

Is the treatment in direct relation with an accident? Yes Non If yes, please describe the circumstances of the accident

Medical information

1.

a. What is the Doctor's medical diagnosis/condition (mandatory field)?

b. International Classification of Diseases (ICD) – 10 code:

2. When did you first present/ were aware of any signs/symptoms before treatment was sought? (mm/dd/yyyy):

3. When was the condition first diagnosed? (mm/dd/yyyy):

4. Describe briefly the symptoms experienced, the type of treatment and medical investigation reports:

5. Has this condition been diagnosed or treated previously? Yes No

If yes, please provide the detailed treatment, diagnosis provided, and any relevant medical reports/investigation reports.

6. Date, Names and Addresses of Doctors previously consulted:

Declaration and consent clause – To be complete by patient (or parent/guardian if a minor)

I hereby authorize the Medical Department of Henner to investigate or seek further medical information regarding this claim.

I confirm that this claim submission is not related to any pre-existing medical condition that has been excluded from my/my dependents' health insurance coverage at the inception/renewal of my policy. I further certify the accuracy of the information completed and will only request one reimbursement of the invoices attached.

I acknowledge that misrepresentation, forgery, falsely certifying facts material to the claim, or abuse by any member will result in immediate recovery of monies and suspension and/or forfeiture of benefits.

Patient's signature*:

Date (mm/dd/yyyy):

**If the patient is a minor: a parent or a guardian.*

**If the patient is unable to complete/sign: his/her spouse or an adult family member.*

Section C – To be completed by the Attending Physician for hospitalization and outpatient claims that require follow up visits. This section is not needed for maternity, dental and vision claims*

**Note: any admin fees chargeable to complete this form will be borne directly by the claimant*

Medical information

1.

a. What is your diagnosis of the patient's condition?

b. International Classification of Diseases (ICD) – 10 code:

2. What were the symptoms experienced by the patient prior to consulting you?

3. How long has the patient been experiencing these symptoms prior to consulting you?

4. When did the patient first consult you for this condition? (mm/dd/yyyy)

5. Have you treated the patient previously for a similar or related condition? Yes No

If yes, please provide a brief history including dates and details of treatment given below.

Date (mm/dd/yyyy):

Treatment:

6. Has the patient been treated previously by another physician for a similar or related condition? Yes No

If yes, please provide the information below.

Date (mm/dd/yyyy):

Treatment:

Doctor consulted:

Address:

7. Where treatment is related to any of the following conditions, please underline the condition: birth defect, congenital condition, fertility/assisted conception, contraception, psychiatric/psychological/mental/nervous condition, behavioural disorders, development abnormalities, cosmetic treatment.

Attending physician details

Name:

Address:

City:

Postal Code:

Country:

Physician's Signature/Clinic Stamp

Date (mm/dd/yyyy):