

InterGlobal HealthCare Plans

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 +971 4 445 2300 or email claimsenquiries@interglobal.ae if you require any further assistance.

About your claim

Your claim will be processed by InterGlobal Limited on behalf of the insurer. Please enclose the original invoices – photocopies, receipts and credit card vouchers are not acceptable. We are unable to return original documents, but we will be happy to provide certified copies on request.

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: <input type="text"/>
Daytime telephone:	<input type="text"/>
Evening telephone:	Fax: <input type="text"/>

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?
 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.

 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 option below). Please note that we will only issue payment to the claimant if they are 18 or over, another dependant on your plan if they are 18 or over, the main member on the plan, or the planholder.

<input type="checkbox"/> 1. Bank transfer – please complete this information for bank transfer payments (note that this is the quickest and safest method of payment).	
Name of account holder:	Account number:
Currency of bank account:	

Please ensure that you complete the mandatory information required below – failure to do so may result in delays in you receiving the claim settlement and you incurring additional bank charges.

a) IBAN number (mandatory for all payments within the EEA (European Economic Area), Kuwait and UAE (United Arab Emirates)):
Name of your bank:
Address of your bank:

Or

b) BIC/SWIFT code (mandatory for all other transfers):
Name of your bank:
Address of your bank:

Also, to help us direct your payments efficiently please supply as relevant:

Sort code (mandatory for UK banks): <input type="text"/> <input type="text"/> <input type="text"/> 6 digit number	Routing Code/Branch Code:
ABA number (mandatory for transfers to US located banks): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 9 digit number	
RUT (mandatory for CLP (Chilean Peso) transfers):	
<input type="checkbox"/> 2. Foreign draft. Please specify currency:	
Name to appear on the draft:	Currency of the draft:

F Claim details

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

G Data Protection Notice and Declaration

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to Law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below;

I would like information about any claims I may have be provided to:

Name:	Relationship:
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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 dental 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 that I give explicit consent, (on behalf of myself and any family members specified in this form) for Interglobal Limited to process our personal information with respect to our claim and I confirm that I have brought this Notice to the attention of these family members.

I authorise and request any hospital, specialist, physician or other health provider to furnish Interglobal Limited or their duly authorised agents with such information as they may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the consideration of this claim.

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

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.

Practice stamp:

1. Contact details

Name of medical practitioner/specialist/consultant/therapist:		Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/>	
Qualifications:	Email:		
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. Referralsa) 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. Symptomsa) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the member under the influence of alcohol, drug or any other intoxication substance at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment proposed:	
Is a follow-up visit needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when (dd/mm/yy)?

6. Investigations requested

Please provide details:

7. Type of conditionIn 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 medicineNumber of sessions needed: **9. Hospital admission**Has the patient been admitted to hospital for this condition? Yes NoIf yes, please provide admission date (dd/mm/yy): And discharge date (dd/mm/yy): **10. Cosmetic treatment**In your opinion, is the treatment for cosmetic reasons? Yes No**11. Maternity treatment**When was the LMP (dd/mm/yy)? Is the pregnancy a result of infertility treatment/medication, including conception by artificial means? Yes NoIf 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):

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.

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 due to inaccurate information submitted to us.
- 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 sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim.
- 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 and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan.
- We cannot make payment in the following currencies but if in doubt, please refer to us:
 - Chinese Yuan Renminbi (RMB)
 - Brunei Dollars (BND)
 - Russian Ruble (RUB)
 - Venezuelan Bolivares (VEB)
 - Zimbabwean Dollars (ZWD)
 - Lebanese Pounds (LBP)
- Please note we cannot issue foreign drafts or cheques to banks based in Qatar.

Sections G and H

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

No claims discount (NCD)

The NCD applies to individual and family plans and not group plans. Any claims made under the wellness benefit or under a benefit on an optional add-on plan will not affect the NCD.

Claims made under all other benefits will affect your NCD.

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?