# Claim form

If you have any queries about your claim contact our Customer Services team on:
Telephone +44 (0) 1273 323563 Fax +44 (0) 1273 820517 E-mail; info@bupa-intl.com

BUPA International

**Return this form with original invoices to: BUPA International, Russell Mews, Brighton BN1 2NR, United Kingdom.**

*Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.*

Please ensure that all sections of the claim form are fully completed. Please note that claims payment may be delayed if all sections of the claim form are not completed in full. The form should be returned to us within six months of the initial treatment date. Always enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable.

**Please complete a new / separate claim form:**
- for each patient
- for each in-patient / day-case stay
- for each medical condition
- for each currency

**For any claim within six months of initial treatment:** we require only invoices and a letter stating the condition they relate to together with payment instructions.

**For any claim after six months of initial treatment:** please complete and return a new claim form with the invoices.

Unless you request the return of your documents, they will be microfilmed and destroyed

## 1 Patient's details - to be completed by the person undergoing treatment

| | | |
|---|---|---|
| Title | Family name | |
| First and middle names | | |
| Date of birth day month year | | Age last birthday |

Patient Membership number *(as above)*: BI – – –

Company name *(if applicable)*:

## 2 Principal member's details - to be completed by the member

| | | |
|---|---|---|
| Title | Family name | |
| First and middle names | | |
| Date of birth day month year | | Age last birthday |

| | | | |
|---|---|---|---|
| Correspondence address | | | |
| P O Box/Street address | | City | |
| Postal/Zip code | State | Country | |
| Telephone No. Daytime | Evening | Fax No. | |
| Is this address: temporary? ☐ permanent? ☐ | E-mail | | |

*Please tick this box if you have a residence in the USA:* ☐

***Please ensure that you sign the section on the reverse of the claim form.***

## 3 Medical details *(all sections must be completed by the doctor in overall charge of the patient's treatment)*

BLOCK CAPITALS PLEASE

| | |
|---|---|
| Diagnosis and condition | ICD 9 code |
| | |
| | |

| |
|---|
| Details of treatment and/or prescribed drugs |
| |
| |

| | |
|---|---|
| Details of operation | Procedure code OPCS |
| | |
| | |

Date when symptoms first noticed by the patient: D D M M Y Y

Has the patient been treated for this condition before? YES ☐ NO ☐

**Hospital dates**

Admission date: D D M M Y Y

Discharge date: D D M M Y Y

***Please complete a new claim form for each in-patient/day-case stay.***

**Name and address of admitting hospital**

| | | |
|---|---|---|
| Name | | Reference Number |
| Address | | |
| Telephone Number | Fax Number | E-mail |

**Medical practitioner's details**

| |
|---|
| Name |
| Address |
| Qualifications |

Medical practitioner's signature ✗ Date ✗

## 4 Payment details

Who should we pay? (please tick) Provider* ☐ Patient ☐ Principal Member ☐ Group ☐

In which country did the treatment take place?

What is the currency of the invoice?

Total amount of claim?

| | | | |
|---|---|---|---|
| Payee | Name | | |
| Bank details | Name | | |
| Full street address | | | PO Box |
| City | Postal/Zip code | | State |
| Country | Telephone No. | | Fax No. |
| Account number | | | Sort code |

Provision of Bank Details will allow a quicker electronic payment. If we are unable to pay directly to a bank account a cheque will be forwarded to the address of whoever is indicated above.

Should payment be made in the currency of the invoice? (please tick) ☐ or

Should payment be made in the currency of your subscription? (please tick) ☐

*UK and participating hospitals will automatically be paid directly unless the invoices are receipted.
We reserve the right to send any benefit due to an appropriate person - for example, the executors of the will of someone who has died or the dependant on your membership who has paid the bill.

**We can settle claims in over 80 currencies. In the few cases where we cannot settle in the currency of the invoices, we will reimburse you in the currency of your subscriptions.**

## 5 Your consent to obtain a Medical Report

**Please read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.**

In order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration below.

You can choose from three courses of action:

1. You can give your consent without asking to see the doctor's report before it is sent to us. The report will then be sent directly to us by the doctor.
2. You can give your consent, but ask to see any report before it is sent to us, in which case you will have 21 days, after we notify you that we have requested a report from the doctor, to contact your doctor to make arrangements to see the report. If you fail to contact the doctor within 21 days, he will be entitled to send the report direct to us. If however you contact your doctor with a view to seeing the report, you must give the doctor written consent before he can release it to us. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to us.

   Should you give your consent to us obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to accept your claim.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask him within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your doctor may also make a reasonable charge for his services.

### Patient's family doctor/general physician - Doctor's details - the name and address of the doctor who holds the patient's medical records.

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | | |
| Postcode | Telephone No. | | Fax No. |
| E-mail for doctor who holds record | | | |

The undersigned authorises and requests any hospital, specialist, physician or other health provider to furnish BUPA or its duly authorised agent acting on BUPA's behalf with such information as BUPA or that agent may seek from them in connection with any treatment or other services provided to me or my dependant for the purpose of BUPA considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

I do (not)* wish to see a copy of any medical report before it is sent to BUPA.(Delete the word NOT if you wish to see a copy of the medical report before it is sent to BUPA).

If you have any other medical cover eg. health, travel, or motor insurance, please give name(s) of the insurer(s) concerned, in case we need to contact them.

| | |
|---|---|
| Insurer | Policy No. |
| Address | |
| | |
| | |

**DECLARATION** to be completed by the patient

I confirm that the information I have given on this form is accurate and correct, to the best of my knowledge.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, to process my personal information with respect to this claim.

Patient's signature, a parent or guardian if patient is under 16

Signature ✗ Date ✗

### BUPA Data Protection Notice

**Purpose:** Personal data collected on you, and where appropriate, your family, will be used by BUPA International to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.
**Confidentiality:** The confidentiality of patient and member information is of paramount concern to BUPA International. To this end, BUPA International fully comply with UK Data Protection Legislation and Medical Confidentiality Guidelines.
**Medical Information:** Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the BUPA International Agent/Adviser where you have requested the Adviser to assist you.
**Member details:** All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.
**Telephone calls:** In the interest of continuously improving our service to members, your call will be recorded and may be monitored.
**Research:** Anonymised or aggregated data may be used by BUPA International, or disclosed to others, for research or statistical purposes.
**Regulation:** BUPA is a member of the General Insurance Standards Council, which regulates the Insurance Activities of its members. Personal data may be disclosed to GISC as part of this system of regulation. Such data will be subject to a duty of confidentiality on the part of GISC.
**Fraud:** Information may be disclosed to others with a view to preventing fraudulent or improper claims.
**Names and Addresses:** BUPA does **not** make the names and addresses of members or patients available to other organisations.
**Keeping you informed:** BUPA would, on occasion, like to keep you informed of BUPA products and services which it considers may be of interest to you.
**Contact Address:** If you do not wish to receive information about BUPA's products and services, or have any other Data Protection queries please write to the BUPA Group Information Protection Manager, at BUPA House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@BUPA.com.

Please refer to your membership certificate for details of your insurer.