MC Claim Form 07_aw 9/5/07 09:11 Page 1

Claims

MediCare INTERNATIONAL

Please complete and return to:
MediCare International
One Hundred Whitechapel
London E1 1JG, United Kingdom
Telephone: +44 (0)20 7816 2033
Facsimile: +44 (0)20 7816 2188
E-mail: medicare@medicare.co.uk
Website: www.medicare.co.uk

Claim Form

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES
FAILURE TO COMPLETE THE FORM FULLY WILL DELAY SETTLEMENT OF YOUR CLAIM
PLEASE ENSURE YOU HAVE READ THE CLAIMS PROCEDURES PRIOR TO MAKING A CLAIM

How to make a claim

Written notification of claims must be provided within 90 days of the initial consultation, even where original invoices are not yet available. To help us deal with your claim promptly, please:

1. Complete a separate claim form for each illness/accident/dental treatment/maternity or wellness benefit claim and each Insured Person
2. Ensure that the doctor or dentist who treats you fully completes the sections overleaf
3. ALL questions must be answered in full (ticks or dashes will not be acceptable)
4. ALL routine dental treatment must be supported with confirmation of six-monthly check-ups
5. When calculating claims, the exchange rate at time of adjudication is used.
6. Original accounts for treatment received must be submitted.
7. **Important: all inpatient claims and any other claim likely to exceed £2,500 from the outset must be pre-authorised by CEGA. Failure to do so will result in the insured person being responsible for £1,000 of treatment costs.**

Section A – Patient Information

TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE

1. Full name:
   Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other
   Surname:
   Forenames:
2. Date of birth:
3. Certificate number:
4. Sex: ☐ Male ☐ Female
5. Full mailing address of claimant:
   Postcode:
   Country of residence:
   Telephone:
   Facsimile:
   Email:

Section B – Claim Information

TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE

6. State the nature of illness and the date upon which symptoms first occurred:
7. Have you ever received treatment (including prescription drugs) for this condition or any related condition before this episode. Please provide dates and details of previous treatment.
8. How long have you had these symptoms before consulting your doctor?
9. If the cause of the illness relates to an accident, state the date of the accident and give brief details of the circumstances and injuries received:
10. Do you have any other insurance that provides cover for healthcare benefits?

11. Date of Treatment	List Expenses for Which Reimbursement Claimed (Original accounts will be required)	State Currency and Amount Paid	State in Full, to Whom you Wish Settlement Paid	Currency of Settlement

Section B Cont'd over...

Please note that MediCare has authority from your insurers to handle claims on their behalf subject to certain limitations. If you do not wish us to act on this claim as agent of both yourself and insurers, you should advise us by return and we will arrange for handling of your claim to be managed by insurers themselves.

DATA PROTECTION: The information you have provided will become part of the personal data held by MediCare International and will be used for the provision and administration of insurance products and services. MediCare International may disclose your personal data to insurance companies and to their agents for underwriting, claims handling and fraud prevention purposes. In addition, it may seek information from insurance companies to check the answers you have provided. Full details of MediCare International's processing of personal data appear in the register maintained by the Information Commissioner.

MAY 2007

12. Are further accounts to be submitted? If so please give details:

13. Is this a continuation of previous or current treatment for which you have already claimed under this policy? If yes, please give details, including claim reference number:

14. Please provide the name and address of your usual General Physician:

15. Please provide details or other doctors and or surgeons who have treated you for this or related conditions

16. I authorise (I) the release of any medical information necessary to process this claim and (2) the processing of any medical information or other personal data provided by me or by my physician/dentist and the disclosure of such information to underwriters via claims handling agents and, where relevant to loss adjusters for the purpose of this claim. I declare that I have not received medical advice or treatment or experienced symptoms for the illness/injury for which I am now claiming within two years prior to the first date of my insurance cover under this policy. (This does not apply if you are insured under a Group Plan where the Pre-Existing Condition exclusion has been waived). To the best of my knowledge all the afore mentioned particulars are true.

Signature of Insured Person or Legal Representative:

Date:

THE SECTION(S) BELOW MUST BE COMPLETED BY THE TREATING PHYSICIAN/DENTIST

Section C – Medical Information

TO BE COMPLETED BY TREATING PHYSICIAN

17. Please state the date on which the patient first consulted you for this or any similar or related condition:

18. When did symptoms first occur?

19. Please give name and address of the referring Physician:

Postcode:

Telephone:

Facsimile:

Email:

20. Please give your diagnosis of the illness/injury:

21. Is the condition likely to be considered congenital or a birth defect? If so please provide details:

22. Please give a history of this or any related or similar conditions with dates on which any previous treatment or investigation took place:

23. If all or a part of the treatment was in respect of elective cosmetic surgery, please indicate the amount or the proportion of the costs involved:

24. Have you any reason to believe that the treatment for the same or similar condition has been given previously? If yes, give details:

25. In respect of claims for maternity care please state the expected delivery date and the date on which the patient first consulted you for this pregnancy:

Signature of treating physician:

Please state your qualifications

Section D – Routine Dental Treatment Information

TO BE COMPLETED BY THE TREATING DENTIST

a. Has the patient attended for routine check-up in the past 6 months and was all necessary treatment concluded?

b. In your opinion has the patient maintained good dental hygiene?

c. Please describe dental necessity for this claim?

d. Please print your name and address:

Postcode:

Telephone number:

Fax number:

Email address:

Signature of treating dentist:

Please state your qualifications