# Medical Claim Form

## Please read the instructions carefully

**Please complete Section A for all claims and ensure that:**

- ☐ The doctor has written the diagnosis on the bill or receipt, or on a separate note, and
- ☐ Details of any treatment, investigations or procedures are also itemized on the bill or receipt.

**Please have your Physician fill out Section B if your claim involves any of the following:**

- ☐ Inpatient or emergency ward treatment
- ☐ An operation of any kind
- ☐ Inpatient or emergency ward treatment
- ☐ Medication (other than for colds, flu etc.)
- ☐ Any diagnostic test (e.g. blood test, x-ray, CT scan, MRI, medical test etc).
- ☐ Accidental injury or a Major illness
- ☐ Consultation or review by a Specialist of any kind

## Section A (to be completed for all claims)

### Policy/Member Information

Name of Patient:

US Citizen: ☐ No ☐ Yes, SSN:

Policyholder Name:

Policy Number:

Member Number:

Address:

Country:

Telephone (H): (O)

Fax: Email:

### Claim Settlement

Total Amount Claimed:

Payment Method:

☐ Cash Collection (in VND and up to VND 20,000,000 only)

☐ Telegraphic Transfer (VND Account)

Account Name:

Bank Account No.:

Bank Name:

Bank Address:

Sort/Swift Code:

### If this claim pertains to illness:

When and how did this illness first occur? When did you first consult a doctor about this problem or these symptoms?

Have you ever had a similar illness or symptoms? If yes, please give full details below.

### If this claim pertains to an accident:

Date, time, and exact place of accident:

Briefly describe how this accident occurred:

Was a third party involved? If yes, please describe his/her part in this accident and state whether reimbursement or other compensation will be provided.

### Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

### Authorization for Release of Information

I authorize any dentist, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member
(parent if minor)

Date

## Section B (To be completed by the Attending Physician at the Insured Person's Expense)

1. State briefly the nature of illness or injury.

2. When did the symptoms first arise?

3. On what date did the patient first consult you for this condition?

4. Has the patient ever suffered from this condition before?
   ☐ No ☐ Yes (explain)

5. Has the patient ever had any similar condition or related symptoms before this incident?
   ☐ No ☐ Yes (explain)

6. Is this related to any accident or injury, or in any way connected with the patient's employment or job duties?
   ☐ No ☐ Yes (explain)

7. Please provide full reports including but not limited to past medical history, referral letters, investigative procedures, and treatments.

8. (Claims for Surgery) In addition to information in (7) above, please provide name and date of surgical procedure(s), operation notes, pathology report and discharge summary.

9. (Claims involving pregnancy) Please state approximate commencement date of pregnancy or date of Last Menstrual Period (LMP)

### Name & Address of Attending Physician

Physician's Signature

Date

### Important

☐ Have you completed Section A?
☐ Have you signed the Declaration and Authorization for Release of Information?
☐ Have you enclosed all original bills, statements, receipts, and other documents?
☐ Has the physician completed Section B?

Please send completed form and all original bills, statements, receipts, and other documents to:
**GlobalHealth Vietnam Company Limited**
Suite 12A, 4th Floor, Saigon Center
65 Le Loi, District 1, Ho Chi Minh City, Vietnam
Telephone: (848) 3827 0251 / 3827 0228
Fax: (848) 3822 5454

Please contact us if you have questions on how to claim.