

March 09



Global

Medical and Dental Expenses
Claim Form

Medical and Dental Expenses Claim Form

Step 1 You should complete Sections A and B (Please complete in block capitals)

Step 2 Your treating doctor should complete Section C

Step 3 Please ensure that you submit this form within 3 months of the start of your treatment as claims received after this date will not be considered.

Claim reference no. (if known)

Section A – Policyholder/patient details To be completed by the policyholder

Mr Mrs Ms Miss Other _____ First Name: _____ Surname: _____

Date of Birth: _____ Membership/Policy No: _____

Correspondence Address For This Claim: _____

Telephone No: Country Code _____ Area Code _____ Number _____ Fax Number: Country Code _____ Area Code _____ Number _____

Mobile No: Country Code _____ Area Code _____ Number _____ Email Address: _____

Name of Patient (If different from Policyholder): _____ Is this a continuation of a previous claim? Yes No

If 'Yes', please give the claim reference number:

How would you like your claim settled? Bank Transfer Cheque If 'Bank Transfer' please provide the following details;

Bank Name: _____ Bank Address: _____ Country of Bank: _____

Account Holder: _____ Account Number: _____ Bank Sort Code Number: _____

Swift Code Number: _____ IBAN (This can be found on your bank statement): _____

Section B – Details of illness/condition and expenses incurred To be completed by the policyholder/patient

Describe in your own words the nature of your illness/condition: _____

When did you first start to experience the signs and symptoms of this illness/condition? _____

What date did you first see any doctor/dentist for this illness/condition? Day Month Year

Is all or part of this claim recoverable from another insurer/third party? Yes No

Please give details of your usual family doctor/dentist; First Name: _____ Surname: _____

Address: _____

Telephone No: Country Code _____ Area Code _____ Number _____

If treatment was received in your home country, please confirm your travel dates; Date of return to your home country: Day Month Year

Date of departure from your home country: Day Month Year

Please give details of all receipts/invoices included with this claim (continue on a separate sheet of paper if necessary)

Date of receipt/invoice	Details of expense	Amount paid	Specify currency of settlement

Patient signature and release of medical records

To be completed by the patient. If the patient is under 16 then the parent or legal guardian should sign below.

I confirm that the facts stated on this form are true, accurate and correct to the best of my knowledge. I give authority to the insurers or their representatives to contact my medical/dental practitioners for any additional information required in connection with this claim. I understand that the information provided in relation to this claim may be shared with other insurers for the purposes of eliminating insurance fraud. I further authorise Europ Assistance to disclose all records they hold in relation to my policy, and any claim made or assistance provided thereunder, to the Voluntary Health Insurance Board of Vhi House, Lower Abbey Street, Dublin 1. I understand that such records may include confidential medical information or other material of a sensitive nature.

Please complete Section C overleaf

Signed: _____ Date: _____

Section C – This must be completed by the Doctor/Dentist in overall charge of the treatment

Please state the medical condition/symptoms requiring treatment: _____

ICD 9 Code (if applicable): _____

If the patient was referred to you by another doctor/dentist, please provide the following details:

First Name: _____ Surname: _____ Address: _____

When did the patient first:

Date

Details

- | When did the patient first: | Date | Details |
|---|-------|---------|
| a) start to experience/notice the signs and symptoms of this condition? | _____ | _____ |
| b) see any doctor/dentist about this condition? | _____ | _____ |
| c) consult you about this condition? | _____ | _____ |

Where applicable, please give details of any previous treatment /investigations/surgery the patient has undergone for this and/or any related condition including dates:

Please provide details of the treatment/Investigations most recently given: _____

What is your prognosis of the patient's condition? _____

Please give details of any planned treatment: _____

If the treatment is in connection with Pregnancy and Childbirth please give:

Date pregnancy was confirmed: Day Month Year

Expected date of delivery: Day Month Year

Is this a single pregnancy? Yes No

If there are/were any medical complications with this pregnancy please give details: _____

Doctors/dentist details: First Name: _____ Surname: _____

Address: _____

Telephone No.: Country Code _____ Area Code _____ Number _____ Email address: _____

Please sign and authenticate with an official stamp.

Signature: _____ Date: _____

STAMP

Section D – Details of other insurer

- Is this claim the result of an accident for which a claim could be, or is to be made against another person? Yes No

- Are the expenses you are claiming for recoverable either in whole or part from any other source or insurance policy? Yes No

If 'Yes' please provide details

Name of health insurer: _____

Policy number: _____

I/We hereby grant Europ Assistance Holdings Ltd full rights of subrogation in respect of any payments made on My/Our behalf. I/We further agree to fully co-operate with any such recovery efforts from a liable third party or parties.

Please note that if you do not authorize your agent to deal with the claim, we will not be able to discuss any details of the claim with them due to DPA regulations.

Signature(s): _____ Date: _____

Global Tips

- > A fully completed claim form will speed up the assessment of your claim.
- > By giving us your daytime/evening telephone number and email address we can contact you immediately should we need any additional information from you.
- > The quickest way to receive your claim payment is to have it paid directly into your bank account. To ensure payment is made promptly, please ensure that you provide your correct bank details in the relevant section.
- > Unless you tell us the currency in which you want your claim paid, we will pay you in either the currency of the treatment invoice or in euro.
- > If you want your claim paid by cheque, it will be sent to the address you give as your 'correspondence address' on this form. However, if you want the cheque sent to a different address, please provide full details of this address.
- > Expenses incurred should be listed individually in the columns provided in Section B. Please use an additional sheet if necessary. If all of the invoice details are not included then it may result in a delay in assessing your claim.
- > You only need to complete one claim form for each medical condition within each Period of Insurance regardless as to how many different bills you have to send in. If, having submitted your claim form you receive further bills for the same medical condition, just send them in together with an accompanying letter making sure you quote your membership number and claims reference number. Alternatively, take a copy of your original claim form and attach it to any subsequent bills received.

Checklist: Before sending us your claim form:

- > Are all sections of the claim form fully completed?
- > Have you given us full details of the medical/dental condition giving rise to this claim?
- > Are all relevant receipts/invoices attached?
- > Have you quoted your Global membership number?
- > Have you signed and dated the claim form?



If you have any queries regarding your claim, please contact our Customer Service Line:

Tel: +353* 46 90 77 377

For members in the USA call Toll Free:

1 800 852 7747

Email: vhiglobal@europ-assistance.ie

+ First dial the international access code.

* When dialling from the Republic of Ireland, omit 353 and first dial 0.

This form and original invoices to be sent to:

Global Claims Department,
Europ Assistance Holdings Ltd.,
IDA Business Park, Athlumney,
Navan, Co. Meath,
Ireland.

The Voluntary Health Insurance Board (trading as Vhi Healthcare) is a Multi-Agency Intermediary regulated by the Financial Regulator.

Vhi Healthcare is an agent of Europ Assistance Holding Irish Branch for non-life business.

