Pallas GlobalHealth

# Claim Form

## IMPORTANT INSTRUCTIONS TO COMPLETE YOUR CLAIM:

**You may not need to submit this form if:**
- Your receipts, invoices from the doctor, and other supporting documents show all the information we need to process your claim. If in doubt, please see the following points.

**Complete Section A if:**
- Your supporting documents or cover note do not identify the claimant and the policy details.

**Complete Section B if:**
- Your supporting documents do not show any of the following information about your claims: diagnosis, breakdown of services and items rendered, date of service

**Ask the attending physician to complete Section C if:**
- The claim involves hospitalisation, surgery, major illness, complex tests or treatments or accidental injury.

## SECTION A

**Policy/Member Information**

| Patient Name: | Policyholder Name: |
|---|---|
| Policy Number: | Member Number: |

**Contact Details** (if different from policy)

| Address: | | |
|---|---|---|
| City: | Country: | Telephone (H): |
| Telephone (O): | Fax: | Email: |

**Reimbursement Method (If a selection is not made, reimbursement will default to cheque)**

☐ Cheque (Send settlement to address above ☐ Yes ☐ No. If no, please complete a claim reimbursement form with the correct address where we should send the settlement to)

☐ Bank Transfer (receiving bank charges are the responsibility of the member). Please complete a claim reimbursement form if we do not have your banking details on file or if you have changed your banking details.

☐ Credit Card – We will reimburse your claims directly to your VISA or MasterCard in US$. This is only available if the total claims paid per transaction is less than US$1,000. Please complete a claim reimbursement form if we do not have your credit card information on file.

## SECTION B: Details of your Claim

Please complete the table below if your supporting documents do not show these details.

| Patient Name | Diagnosis of condition treated | Date of Service (dd/mm/yy) | Type of Medical Practitioner, description of services rendered & prescribed items | Charges & Currency |
|---|---|---|---|---|
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## 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 doctor, 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



Liberty Insurance.

## SECTION C – To be answered by the Attending Physician

| Patient Name: | | Policy /Member Number: | |
|---|---|---|---|

| |
|---|
| 1. State briefly the nature of the illness, injury or final diagnosis. |
| 2. When did they symptoms first arise? |
| 3. On what date did the patient first consult you for this condition? |
| 4. Has this patient ever suffered from this condition before? ☐ No ☐ Yes (please explain) |
| 5. Has the patient ever had any similar condition or related symptoms before this incident? ☐ No ☐ Yes (please 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 (please 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: I__I__I/I__I__I/I__I__I__I__I (DD/MM/YYYY) |

| Attending Physician Name: | | |
|---|---|---|
| Address: | | |
| City: | Postal Code: | Country: |
| Tel: | Fax: | Email: |

Physician's Signature | Date | Official Stamp

## How to Submit your Claim

**Please send your completed form and related claim documents to us by email, fax or mail:**

**GlobalHealth Asia Limited**
Suite 1401-3, Chinachem Hollywood Centre
1-13 Hollywood Road, Central, Hong Kong
Tel: +852 2526-0918 Fax: +852 2526 0769
Email: pallasclaims@globalhealthasia.com
www.globalhealthasia.com



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