

All claims under £125 or €/US \$200 or HK \$1,500 per condition, please complete Section A, B and C and return this with the original receipt(s) showing the diagnosis and a full breakdown of costs for each condition being claimed for. ALL sections MUST be completed in full for hospitalisation claims and all claims over £125 or €/US \$200 or HK \$1,500. A referral letter from **Your Specialist** should be attached when **You** are claiming for diagnostic tests or covered alternative treatments.

Policyholder

Policy Number

Section A: Patient's Details - To be completed by the member

Surname:

Address:

First Name & Initials:

Date of Birth: day month year

Email:

Contact Telephone Number:

Fax/Mobile:

Do you hold any other insurance? Yes No

Were **Your** injuries caused by an accident? Yes No

If Yes, please provide full details on a separate sheet

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Section B: Claims Settlement - To be completed by the member

Total amount claimed, including currency of claim:

If settlement is to be sent care of **Your** bank or by transfer, please give full details of your bank below:

Currency in which **You** wish settlement to be made:

Bank Name:

State to whom **You** wish settlement to be made, if different to the member:

Bank Address:

Address to where settlement to be sent:

Name of Account Holder:

Account Number **and** Sort Code/Swift Code*:

*Please note payment may not have been credited to **Your** bank account at the time **You** receive your **Advice** from **Us**. **You** will need to check with **Your** bank.*

OR IBAN Number **and** BIC Code*:

**It is essential that this information is completed if we are to complete an international transfer.*

Section C: Declaration

"I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to Goodhealth and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous **Medical Practitioners**."

"I declare and agree that the personal information collected or held by Goodhealth, whether contained in this form or otherwise obtained may be used by Goodhealth, or disclosed or transferred to any organisation for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment, (3) provide marketing material in respect of insurance related services of Goodhealth or its associated companies and (4) process claims or analyse the insurance."

(If patient is under 18 years of age, Parent or Guardian must sign)

Patient's Signature:

Date: day month year

Section D: Claims Information - To be completed by the Patient's Medical Practitioner or Dental Practitioner

Details of **Medical Condition** requiring **Treatment**: *(Please provide the precise diagnosis, if known).*

Underlying cause:

If this claim is for maternity please advise whether the pregnancy is as a result of any form of assisted conception:

How long has this condition been in existence:

When did the patient first become aware of any symptoms prior to seeking medical **Advice**?

Date of first consultation with any practitioner for this condition:

Has this, or any similar condition previously been suffered from?

Please confirm the likely period of **Treatment** & prognosis (if known):

Name & Address of referring Doctor/Dentist:

*Please complete only if the patient has been referred to **You***

Please detail any diagnostic tests performed and attach the results:

This question relates to Dental Treatment only Is this claim for a routine check-up? Yes No

If you have insufficient space in any section, please provide full details on separate sheet

Section E: Medical Practitioner or Dental Practitioner Details - To be completed by the Patient's Medical Practitioner or Dental Practitioner

Name of Practitioner:

Official Stamp

****IMPORTANT** - Please ensure**

Address of Practitioner:

- 1 All original receipts and prescriptions are attached
- 2 The Claim Form is completed in full
- 3 The declarations are signed and dated
- 4 All laboratory tests are attached
- 5 The diagnosis and underlying cause have been confirmed

Tel: Fax:

Email:

This will ensure that your claim is reviewed in a timely fashion.

Practitioner's Signature:

Date: day month year

Important Note - Please ensure **Your** Claim Form is completed in full and returned within six months of **Your** initial **Treatment**. Failure to complete **Your** form in full will result in the form being returned to **You** and will hold up the processing of **Your** claim. Please note Goodhealth is not responsible for any costs associated with the completion of this form or for any further information/document requested by **Us** to assess **Your** claim. The issuing of this Claim Form is in no way an admission of liability.

Please ensure that all costs for non-emergency **In-Patient/Day-Patient Treatment**, all **MRI & CT Scans**, are agreed by **Us**, or **Our** Helpline, in writing (Fax/Mail/Letter) before any planned **Treatment** is undertaken. Planned **Treatment** undertaken without pre-authorisation from **Us** will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the Medical Helpline, as shown on **Your** Membership Card.

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.

Planned In-Patient & Day-Patient Treatment

In the event of a planned admission on an **In-Patient** or **Day-Patient** basis to a **Hospital**, the following steps must be taken. Payment of all expenses incurred by **You** will not be recoverable unless **You** follow these procedures.

- i) Contact **Our** Medical Helpline as soon as reasonably possible prior to admission giving full details of the condition, proposed **Treatment** including dates and name of procedure (if known) together with the name of the **Specialist** and **Hospital** details. (The telephone number is provided on the back of **Your** membership card).
- ii) The Medical Helpline will advise **You** if they have sufficient information to confirm **Your** cover. If not, they will advise **You** what further information is required.
- iii) When sufficient information has been made available to appraise **Your** claim, the Medical Helpline will verbally confirm the basis of **Your** cover and will dispatch written confirmation to **You**.

iv) The Medical Helpline will attempt at all times to make arrangements with the **Hospital** for all eligible bills to be settled directly under International Healthcare Plan. Where this has been arranged **You** should send the original Claim Form and any unpaid invoices (if given to **You** by the **Hospital**) to **Your** Goodhealth Claims Service.

v) Please ensure a new/separate Claim Form for each member, each new **Medical Condition** and each admission to **Hospital** is submitted.

Out-Patient Treatment

If **You** receive medical **Treatment** as an **Out-Patient**, outside of **Our Provider Network Treatment** must be paid for in full by **You** at the time of the appointment and re-claimed from **Us**.

In such circumstances please ensure that a Claim Form is completed by **You** and the **Medical Practitioner** or **Specialist**. Please remit this to **Your** Goodhealth Claims Service with all substantiating proof of **Your** claim, including, but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the **Medical Practitioner**.

Please return **Your** Claim Form to one of the following offices:

For residents of Middle East, Africa and Indian sub-continent:

Goodhealth Claims Service T +971 4 324 0040
Suite 416 F +971 4 324 3550
Oud Metha Building E claims@goodhealth.ae
PO Box 6380
Dubai
United Arab Emirates

For residents of North, Central, Latin America and the Caribbean

Goodhealth Claims Service TF 1 800 914 2177 (inside USA only)
PO Box 144631 T +1 305 443 6267
Coral Gables F +1 305 443 6648
FL 33134 E claims@goodhealthamericas.com
USA

For residents of Far East and Pacific Rim:

Goodhealth Claims Service TF +800 624 81000*
3204A, 32F, Tower 1 T +852 2860 8000
Admiralty Centre F +852 2866 2555
18 Harcourt Road E claims@goodhealth.com.hk
Hong Kong

For residents of Europe and Rest of World:

Goodhealth Claims Service T: +44 (0) 870 442 4386
80 Leadenhall Street F: +44 (0) 870 442 4387
London E: claims@goodhealth.co.uk
EC3A 3HA
England

www.goodhealthworldwide.com

* Toll free number for Goodhealth Claims Service for residents of the Far East and Pacific Rim will work from Australia, Hong Kong, Japan, New Zealand, Philippines, South Korea and Thailand. If you are calling from another location please dial +852 2860 8000.