Medical Claim Form

Please note:

The acceptance of this form is not an admission of liability on the part of the Insurer. Any documentary proof or report required by us shall be furnished at the expense of the Member.

To ensure there is no delay in processing your claim, please return this claim form duly completed with the original itemized invoices, prescriptions, medical reports, referral letters, and other supporting documents, showing the patient's name and date of service. Please note that we reserve the right to request additional documents or information as we deem necessary. All medical claims must be submitted to us within 180 days of the treatment date.

A new, separate claim form must be submitted for each patient, each medical condition, and each currency.

Please complete all answers in BLOCK letters. Please use a separate sheet of paper to provide full details if necessary.

1. Policy and Patient Information

Name of Policyholder: Policy Number:

Telephone Number (+ country code): Mobile Number (+ country code):

Email Address:

Name of Patient (if different from the above):

Member Number: ID/Passport Number:

Date of Birth (dd/mm/yyyy): Gender: ☐ Male ☐ Female

City and country in which treatment was received:

Currency of the claim(s): Total amount of the claim(s):

Is there any claim resulting from a work-related accident or arising from duties of employment? ☐ Yes ☐ No
If 'Yes', please provide details of the accident and injuries sustained:

Are there any other insurance policies in force or compensation received from a third party? ☐ Yes ☐ No
If 'Yes', please specify the name of the insurer/service provider, product name (if applicable), and amount compensated:

2. Bank Account Details

You may provide your bank details below. In the event we cannot settle in the currency requested, we will reimburse in the currency of your policy. If this section is not completed, we will reimburse the eligible amount to the last bank account we have on record for you.

Currency in which you would like to be reimbursed:

Account Name:

Account Number: IBAN*:

Bank Name: BIC/Swift Code:

Bank Code: Branch Code:

Branch Address:

*IBAN is required if your bank is within the EU, or if your country requires an IBAN (e.g. Qatar, Saudi Arabia, Turkey).

3. Claim Details

Please list below the details of each invoice for which you are seeking reimbursement. If the invoice does not include the diagnosis/medical condition, please ensure that the information is provided below. If there is insufficient space, please provide details in separate sheets of paper.

Date(s) of Service	Description of Treatment/Expenses (e.g. Pre-Hospi, Post-Hospi, GP, Dental)	Diagnosis/Medical Condition	Currency & Amount Paid

Applicable to Physiotherapy & Complementary Therapy cases only. Please provide the referral details* below:

Name of referring doctor:

Date of referral (dd/mm/yyyy):

Address:

Telephone Number (+ country code): Fax Number (+ country code):

*Please attach the referral letter as a supporting document in order for the claim to be considered.

4. Medical Details

This section must be completed by the treating doctor/dentist responsible for the patient's treatment.

Type of Condition: ☐ Acute ☐ Chronic ☐ Congenital

Please provide details of the symptoms, medical condition, or injury:

Final diagnosis and ICD 10 code:

When did the patient first see a doctor for this condition (dd/mm/yyyy)?

What date did the patient first report experiencing symptoms related to this condition (dd/mm/yyyy)?

Please provide details of any underlying cause(s) of the condition being treated:

Has the patient previously suffered from a similar or related condition? ☐ Yes ☐ No If 'Yes', please provide the below details:

Date(s) of treatment (dd/mm/yyyy):

Details of treatment given:

Details of treatment / medication prescribed to the patient:

Details of any surgery or medical procedure (if any):

Procedure code:

What is the patient's prognosis and what future treatment are planned?

Applicable to Pregnancy cases only (to be completed by the treating doctor):

Estimated Date of Delivery (dd/mm/yyyy):

Is the birth of a single baby expected? ☐ Yes ☐ No

Is the pregnancy a result of assisted conception treatment(s)? ☐ Yes ☐ No

If 'Yes', please provide details:

Admitting Hospital/Facility Details (if applicable):

Name of Hospital:

Address:

Contact Person:

Email Address:

Telephone Number (+ country code):

Fax Number (+ country code):

Admission Date (dd/mm/yyyy):

Discharge Date (dd/mm/yyyy):

Type of Hospital Room:

Daily Room Rate (please indicate currency):

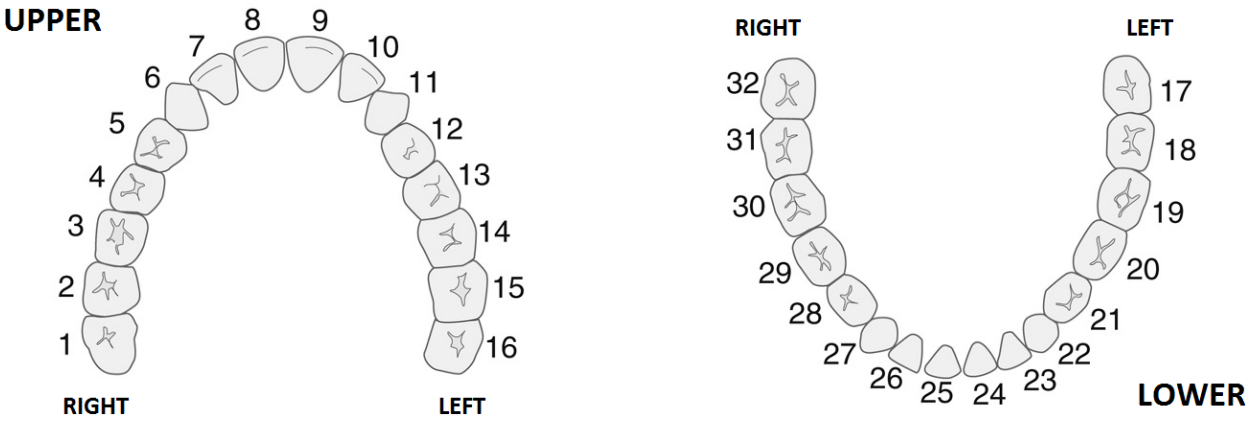
*If the patient was admitted into hospital for one night or more and will not be submitting a claim for the hospitalization, and the patient's policy includes a Hospital Cash Benefit, a confirmation of admission from the hospital noting the full cost incurred and reason for admission must be attached in order for the claim to be considered. It must also bear the hospital stamp to be accepted.

Applicable to Dental claims only (to be completed by the treating Dentist):

Type of Treatment: ☐ Checkup/Preventative ☐ Basic/Major Restorations ☐ Accident/Emergency treatment

Details of Treatment:

Please specify any future treatments you have recommend and indicate which tooth/teeth are involved below:



Medical Practitioner Declaration

I declare that I am the patient's treating doctor, and that the details given above are true, accurate and complete.

Name of Medical Practitioner:

Specialty/Position:

Date (dd/mm/yyyy):

Name and Address of Healthcare Facility:

Signature of Medical Practitioner:

Official stamp:

Data Protection Notice

By signing this form, you confirm you have read, understood, agreed, and consented to PT Asuransi Dayin Mitra Tbk:

- collecting, using, processing, and/or disclosing your personal data;
- collecting personal data about you from sources other than yourself and using, processing, and/or disclosing the same; and
- disclosing and/or transferring your personal data to the participating Insurers, Administrators, Assistance Company, third-party service providers or vendors, and our professional advisors, wherever they are sited;

for the purposes stated in PT Asuransi Dayin Mitra Tbk's Data Privacy Policy.

If you have declared any personal data relating to other individuals, you agree to inform the individual(s) about the content of our Data Privacy Policy, and obtain prior consent to act on their behalf to allow for the collection, use, disclosure, and transfer of their personal data in accordance with our Data Privacy Policy.

Declaration & Authorization

Please read the following carefully, and sign below if you understand and accept:

1. I declare that, to the best of my knowledge, all information supplied in this claim form is true, accurate, and complete.
2. I understand and agree that should I make any false, fraudulent or intentionally exaggerated claims, or withhold material facts whatsoever in respect of this claim, the policy will be cancelled without refund of the premiums already paid, and I shall forfeit all rights to recover therein.
3. I consent to the handling of my personal data declared and provided in this claim form, in accordance with the Data Protection Notice as described above.
4. I authorize any hospital, healthcare provider, and/or doctor who has ever attended or treated me, to provide the Insurer or their appointed authorized representatives, with any and all information and medical records relating to any illness or injury, as may be necessary to access this claim.
5. I authorize _____ to act for and on my behalf in relation to the administration of this claim, which may include the disclosure of sensitive personal information.
6. I agree that a photocopy, facsimile or scan of this authorization shall be considered as effective and valid as the original.

Name of Patient:	Signature of Patient:	Date (dd/mm/yyyy):

Name of Policyholder:	Signature of Policyholder (if patient is under 18):	Date (dd/mm/yyyy):

Please send the completed claim form, with all relevant supporting documents, to:
International Global Health Claims
c/ Integrated Health Plans Pte Ltd
10 Chang Charn Road #04-01
Singapore 159639

Please contact the following if you need assistance completing this form:

- Member Hotline: +65 6715 6401
- Fax Number: +65 6715 9429
- Email Address: **ighclaims@safemeridian.com**

This product is insured by PT Asuransi Dayin Mitra Tbk and developed by PT Astro Pertama Indonesia

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