CARE
Your Health Is Our Priority

Medical Expenses Claim Form

Please complete in BLOCK capitals ensuring ALL relevant fields are completed.

Sections 1, 2 and 3 to be completed by the Policyholder. Sections 4 and 5 to be completed by the Provider of Treatment

1. Policyholder Details | As shown on your membership card

Member Number:

Member Number Policy Number:

2. Patient Details

Date of Birth:

Title: Mr Mrs Miss Dr

First Name(s):

Surname:

1. Are you claiming cash benefit for in-patient treatment received without charge? If "Yes", please state the admission and discharge dates and enclose a certificate from the hospital confirming the dates of stay: **Yes** **No**

Admission Date (DD/MM/YY):

Discharge Date (DD/MM/YY):

(DD/MM/YY)

2. If the claim is related to pregnancy what was the date of your last monthly period:

   The date on which the pregnancy was confirmed:

   Estimated Delivery Date:

3. Is this claim the result of an accident for which a claim may/is to be made against a third party? If "Yes" please provide details: **Yes** **No**

4. Are there either completely or in part any expenses that are recoverable from any other source or insurance policy? If "Yes" please provide details: **Yes** **No**

5. Has the Policy Excess been Paid? If "Yes" to whom? **Yes** **No**

6. Has the European Health Card been used? **Yes** **No**

3. Payment Details | Our usual practice is to settle eligible bills directly with the physician or hospital concerned. If you have already paid the invoices yourself please send us the receipts and we will reimburse you if, and to the extent that, there is cover, by cheque or wire transfer direct to your bank account. For reimbursements, please complete this section with your bank account details. We cannot reimburse to credit or debit cards, so please do not list any card numbers on this form.

Full name of the payee:

Name and address of the bank:

Account Holder's Name:

Account Number:

Bank Sort Code:

IBAN Number:

Swift/BIC Number:

4. Medical Practitioner Information: To be completed by the Provider of Treatment

Name of Doctor/Specialist:

Name and address of Hospital/Clinic:

Telephone: **Email address:**

5. Medical Treatment Details: To be completed by the Provider of Treatment

1. Please provide full details of the medical condition requiring treatment along with full details of any investigations, treatment or surgical procedures including the results if already carried out.

ICD CODE or relevant diagnostic code: **OPCS CODE or relevant surgery code:**

2. On what date did the patient first present to you or any other doctor for this condition? (DD/MM/YY)

3. Prior to consulting you, when did the patient first notice any signs or symptoms of this condition? (DD/MM/YY)

4. Are you aware of any treatment, investigations, advice, medication, or has the patient followed any special diet for this or any related illness in the past? If "Yes" please give details and dates: **Yes** **No**

5. Please give any other medical history relevant to the illness or injury being claim for:

6. Future treatment plan, including proposed frequency and overall length of treatment and expected dates of treatment sessions:

7. Circumstances of injury or illness:

Doctor's Signature:

Doctor's stamp:

Signed:

Date (DD/MM/YY):

Full Name (Please Print):

Protection of Personal Data

We collect and process your personal data for the purposes of handling your claims. For more information please read our Privacy Policy at our website www.akdinsurance.eu

Declaration

I declare that the information I have provided above is true and accurate.

Date (DD/MM/YY):

PLEASE READ THE STATEMENTS MADE ON THE REVERSE OF THIS FORM AND ANSWER THE QUESTIONS, SIGN AND DATE THE FORM.

FAILURE TO DO SO MAY AFFECT THE INSURER'S ABILITY TO PROVIDE THE INSURANCE COVER FROM WHICH YOU BENEFIT AND MAY PREVENT THE INSURER FROM PROVIDING COVER FOR YOU AND HANDLING YOUR CLAIMS.