

GlobalHealth

GENERAL CLAIM FORM



WILLIAM RUSSELL
Peace of mind wherever you are

PLEASE NOTE: Claims for dental and maternity treatment must be made on their own claim forms which are available at www.william-russell.com or by calling +44 1276 486455.

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY.

SECTION A & B MUST BE COMPLETED BY THE PATIENT, OR BY THE PATIENT'S GUARDIAN OR LEGAL REPRESENTATIVE.

SECTION C MUST BE COMPLETED BY THE TREATING DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE DOCTOR.

ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

SECTION A – To be completed by the patient or the patient's guardian or legal representative

1. CLAIMANT DETAILS

Full name of Global Health policyholder: _____ Title: Mr/Mrs/Miss/Ms/Dr _____

Full name of patient (if not the policyholder): _____ Date of birth: _____

Global Health plan policy number: _____ Sex: Male Female _____

Full mailing address: _____

Telephone: _____ Fax: _____ Email: _____

Please state the name and address of your personal physician (General Practitioner):

Name: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

2. DETAILS OF THE CONDITION BEING TREATED

Please describe your symptoms: _____

When were you first aware of your symptoms? _____

When did you first consult a doctor with regard to these symptoms? _____

What is your doctor's diagnosis? _____

Have you ever suffered from this or any related condition before? YES NO

If yes, when did you suffer from this or the related condition? _____

SECTION B – Payment details and declaration

1. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the original, fully itemised accounts. We cannot accept copies.

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Please state currency and amount paid

2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

PAYMENT TO YOUR VISA CARD NB. We can only make payment to a visa card, and payment will be made in your plan currency.

Card number: _____ Name on card: _____ Expiry Date: _____

Address to which card registered (if different from above): _____

PAYMENT TO YOUR BANK ACCOUNT

Currency in which you would like to be reimbursed: _____

Bank name and address: _____

Account holder name(s): _____ Bank account number: _____

Sort code: _____ BIC Number/SWIFT code*: _____ IBAN number*: _____

* BIC/SWIFT and IBAN details are necessary for all transfers to European bank accounts

BANK DRAFT Please state the name of the Payee and the currency of the bank draft: _____

3. DECLARATION AND AUTHORISATION AND CONSENT BY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover? No, I have no other health insurance cover
 Yes, I have other health insurance cover with: _____

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell Ltd or to their authorised representative any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian).

Print name of patient or guardian: _____

Signature of patient or guardian: _____

Date: _____

SECTION C – To be completed by the patient's doctor

1. PATIENT DETAILS

Patient's full name: _____ Sex: Male Female Date of birth: _____

Was the patient referred to you? YES NO

If YES, please state the name and contact details of the referring doctor: _____

2. DATES

For how long have you known the patient? _____

On which date did the patient first consult you for this particular condition? _____

In your professional opinion, for how long before this date would the patient have been aware of their symptoms? _____

3. YOUR DIAGNOSIS

What is your clinical diagnosis? _____

Please advise tests performed and attach test results: _____

4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of medications currently being prescribed to this patient: _____

5. MEDICAL HISTORY

Please answer each of the following questions:

1. Has your patient previously suffered from this or from any related condition? YES NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred: _____

2. Does your patient have a history of any of the following:-	YES	NO	Details and date of onset
High blood pressure, high cholesterol, heart or circulatory disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma, respiratory or allergic conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine, bone, joint or muscle conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric, psychological or mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other disease or injury requiring in-patient treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____

6. DECLARATION BY DOCTOR

I declare that I am the patient's treating Doctor, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature: _____ Date: _____

Please print your name and address: _____

Contact telephone number: _____ Fax: _____ Email: _____

Qualifications: _____

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP