PREMIER INTERNATIONAL HEALTHCARE

MEDICAL CLAIM FORM

Note: (i) The insured member is required to complete Section A and attach all the original medical bills when filling the claim.
(ii) The attending physician/ surgeon is required to complete Section B.
(iii) Use a new Claim Form for each separate claim or illness.

SECTION A: TO BE COMPLETED BY INSURED MEMBER

Policy Number	

Name of Insured Member								Sex	M		F		
Passport No.		Marital Status											
Occupation		Date of birth	D	D	M	M	Y	Y	Y	Y			

if other than the insured member

Name of Patient								Sex	M		F		
Passport No.		Marital Status											
Occupation		Date of birth	D	D	M	M	Y	Y	Y	Y			

Present Home Address													
Town/ City		Country											
PostCode/ Zip Code		Email Address											
Work Contact (Tel.)		Home Contact (Tel.)											

Sickness/ Accident: Nature of Illness/ Final Diagnosis. If it is due to Accident, pls describe nature of injury

Conditions: (a)		Date First Treated	D	D	M	M	Y	Y	Y	Y			
(b)		Date First Treated	D	D	M	M	Y	Y	Y	Y			
(c)		Date First Treated	D	D	M	M	Y	Y	Y	Y			
(d)		Date First Treated	D	D	M	M	Y	Y	Y	Y			
(e)		Date First Treated	D	D	M	M	Y	Y	Y	Y			
(f)		Date First Treated	D	D	M	M	Y	Y	Y	Y			

• SETTLEMENT OPTION

Please tick your preferred settlement mode. Kindly note that the payee refers to the Policyholder or Insured Member only.

☐ Bank Cheque (THB)			
☐ Demand Draft. Please furnish name of payee		Currency Type	
☐ Telegraphic Fund Transfer. (Only avaliable if payment is more than US$200) Please furnish bank details			
Name of Account Holder			
Beneficiary Bank Account No.			
SWIF Address/ Clearing Code (if applicable)			
Name of Beneficiary Bank & Branch		Currency Type	
Address of Bank & Branch			

Note: If preferred currency type is not specified, claim will be paid in policy currency.

• DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/ legal guardian if the patient is below 21 years of age)

I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

SIGNATURE OF INSURED MEMBER	SIGNATURE OF PATIENT	DATE

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(continued)

Section B: To be completed by attending physician/ surgeon

Note: If there are multiple doctors, this Section is to be completed by the last attending physician.

Name of Patient		Passport No.	
Final Diagnosis		ICD Code	DRG Code
Other Diagnosis		ICD Code	DRG Code

When did the patient first consult you for this condition?

Please specify the approximate date of discovery date of the illness or injury:

How long has the illness/ injury been existing prior to consulting you?

Nature of Treament:

Date of Treatment rendered:

Doctors previously consulted by the patient for the above condition

Name		Approximate date	D D M M Y Y Y Y
Name of Clinic			
Address			
Name		Approximate date	D D M M Y Y Y Y
Name of Clinic			
Address			

Maternity claims

Please indicate the estimated date of delivery and the date of the patient's last menstrual period

Signature of Physician/ Surgeon Date

Name of Physician/ Surgeon

Name and Address of Clinic/ Hospital

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