MEGA INTERNATIONAL Health Care

Claim Form

IMPORTANT INSTRUCTIONS TO COMPLETE YOUR CLAIM:

Complete Sections A and B, and sign Declaration if:

- You are claiming only for out-patient doctor visits, medications, dental and general laboratory tests,
- The doctor has written the diagnosis on the bill or receipt, or on a separate note, and
- You have not been advised you may require surgery, hospitalization, or specialized testing for this disability.

Complete Sections A and B, and ask your Physician to complete Section C if:

- You are claiming for in-patient, emergency, or surgical claims, or claims involving complex treatments/tests, accidental injury, or major illness.

SECTION A

Policy/Member Information

Patient Name:	Policyholder Name:
Policy Number:	Member Number:

Contact Details (if different from policy)

Address:		
City:	Country:	Telephone (H):
Telephone (O):	Fax:	Email:

Reimbursement Method

Please select Currency of Reimbursement: ☐ IDR ☐ USD ☐ Other Currency: _____

Bank Domicile: ☐ Onshore (Indonesia only) ☐ Offshore (Applicable Charges Applied)

Receiving bank charges are the responsibility of the member. Please provide bank account information below.

Bank Name:		
Branch of Account Opening:		
Account Name:		Account Number:
Sort Code:	IBAN Code:	BIC (Swift) Code:
Correspondent Bank Details (if applicable):		

Account Declaration Statement

☐ Herewith, I declare that the name and account number stated above are truly my personal Account. Anything that happens due to the inclusion error is my responsibility. Should the account name stated above is not the policyholder's own name, or not listed as an insured member on our census, you are required to include Statement Letter with wet signature and stamp duty.

SECTION B *(To be answered by member or parent if a minor)*

If this claim pertains to illness:

When did you first consult a doctor about this problem or these symptoms? How long have these symptoms been present before you first consulted a doctor? Please provide the dates and names of doctors consulted.
Have you ever had a similar illness or symptoms? If yes, please give full details below:

If this claim pertains to an Accident:

Date, time and exact place of accident:
Briefly describe how this accident occurred:
Was a third party involved? If yes, please describe their part in this accident, & state whether reimbursement/compensation will be provided.

DECLARATION

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorize any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent if minor) Date

MEGAINSURANCE

GlobalHealth an april company

SECTION C – To be answered by the Attending Physician

Patient Name: | Policy /Member Number:

1. State briefly the nature of the illness or injury.
2. When did the symptoms first arise?
3. On what date did the patient first consult you for this condition?
4. Has this patient ever suffered from this condition before? ☐ No ☐ Yes (please explain)
5. Has the patient ever had any similar condition or related symptoms before this incident? ☐ No ☐ Yes (please explain)
6. Is this related to any accident or injury, or in any way connected with the patient's employment or job duties? ☐ No ☐ Yes (please explain)
7. Please provide full reports including but not limited to past medical history, referral letters, investigative procedures, and treatments:
8. (Claims for surgery) In addition to information in (7) above, please provide name and date of surgical procedure(s), operation notes, pathology report, and discharge summary.
9. (Claims involving pregnancy) Please state approximate commencement date of pregnancy or date of Last Menstrual Period: I___I___I/I___I___I/I___I___I___I___I (DD/MM/YYYY)

Attending Physician Name:		
Address:		
City:	Postal Code:	Country:
Tel:	Fax:	Email:

Physician's Signature | Date | Official Stamp

IMPORTANT

- ☐ Have you completed Section A?
- ☐ Have you signed the Declaration and Authorization for Release of Information?
- ☐ Have you enclosed all original bills, statements and receipts?
- ☐ If required, have you completed Section B?
- ☐ If you have completed Section B, has your physician completed and signed Section C?

Please send completed form and other documents to:

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Menara Bank Mega Lt. 18
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