Out-Patient Claim Form

Please complete all sections of the claims form in BLOCK CAPITALS and ensure that all original invoices and receipts are attached.
The declaration on this form must be signed and dated by the patient or by the main policyholder if the patient is under the age of 18. Failure to do so may result in delays in the processing of your claim.

If you have made a claim for the same dental condition before, please state the claim number where possible:	

1. Patient Details

Full Name:	Date of Birth:
Postal Address:	Telephone Number:
	Email Address:
Policy Number:	Member ID:

2. Policy Details

Name of Main Policyholder:	
Policy Number:	Member ID:

3. Bank Account Information

Name of Account Holder:	
Account Number:	Sort Code:
IBAN*:	Swift/BIC*:
Claim Payment Currency:	
Bank Name and Postal Address:	

Please fill out your bank details above so that we can pay your claim into your bank account of choice. Please note that we are unable to refund your claim to a debit or credit card.
*Note: This information is required for payments to be made outside of the UK. Please contact your bank if you do not have these details. If currency type is missing the default currency will be paid in USD.

4. Additional Information

Does the patient hold any other insurance plan or policy that could also provide coverage for these medical costs?
Yes ☐ No ☐

If Yes, provide the other insurer's name and contact details, and include the patient's plan or policy number with that insurer:

Is the claim the result of an accident? Yes ☐ No ☐

If Yes, provide the circumstances of how, when and where the accident happened:

Was there another person/company involved in the accident? Yes ☐ No ☐

If Yes, provide the name of the person/company involved, insurer's name, contact details and their policy number:

5. Claim Information

Confirm the reason for visiting the medical practitioner and include details of the symptoms/medical condition for which you have been treated:

Please confirm the name, address, email address and telephone number of the doctor that you have seen:

Have you ever suffered from or received treatment for this medical condition before? Yes ☐ No ☐

If Yes, please provide details of previous episodes, including relevant dates and treatment provided

If you suffered an injury, was it the result of an accident? Yes ☐ No ☐

Did the injury occur while you were taking part in a professional sport? Yes ☐ No ☐

If Yes, please confirm the circumstances of the accident, including how it happened, the location and the date and time:

Provide brief details of the treatment or investigations:

Please provide a breakdown of the invoices being submitted with this claim:

Invoice reference	Invoice date	Treatment date, if different	Amount (including currency)

*Use a separate sheet if you need more space.

Has further treatment for your condition been planned? Yes ☐ No ☐

If Yes, please provide details of the treatment plan:

6. Declaration

Global Benefits Advisors have appointed Healix International to manage your claims on their behalf.
I confirm I have read the information in this form and declare that all the information I have given is, to the best of my knowledge, true and correct.
I consent to Healix International reviewing the information on this form.

Signature:	Print Name:	Date:

MEDICAL CERTIFICATE

In order for Healix International to process your claim as quickly as possible, you can take this form to your consultation, have it completed by the treating doctor and send this when you submit your claim. If you choose not do so, it may be necessary later on for Healix International to return to you to have this completed if required.

To be completed by the patient:

I, the patient, hereby authorise Healix International to obtain further medical information from the doctor completing this medical certificate should it be required for the purpose of this claim.

Signature:
Date:

To be completed by the Medical Practitioner

Patient Details:

Patient Full Name:	Patient Date of Birth:
Date the patient first registered with you/the clinic/the hospital:	

Please provide full details of the symptoms/medical condition that the patient has been suffering from and that you have been treating them for:	
How long had the patient been suffering from the symptoms listed above prior to consulting with you or any other medical practitioner?	
What date did the patient first present the symptoms/medical condition listed above to you or any other medical practitioner?	

Please provide details of any tests and investigations that the patient has had in relation to the above, and provide the results of these:

What is the diagnosis that has been made? If there is a final diagnosis, please also confirm the date it was made:

Is it: Provisional? Final? Date confirmed:

Would you consider the condition to be: Acute? Chronic?
An acute episode of a chronic condition?

To your knowledge, has the patient ever previously suffered from the symptoms listed above? Or previously been diagnosed with this or any related condition? Yes ☐ No ☐

If so, please provide details including investigations/results, diagnosis made/date of diagnosis and treatment received/dates of treatment where possible:

Is there any underlying cause or condition? If so, please provide details:

Has the patient been given a terminal prognosis?	Yes ☐	No ☐
If so, please confirm the date that the condition was confirmed as terminal:		

Is the condition a result of an accident?	Yes ☐	No ☐
If so, was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident?	Yes ☐	No ☐

Please provide the full treatment plan recommended for the patient including the expected length of treatment and/or the dates of each treatment:

If the patient has been referred for complementary treatment, please indicate the type and the number of sessions:			
Chiropractor:	Osteopath:	Homeopath:	Acupuncturist:
Dietician:	Traditional Chinese Medicine:		

Was the patient referred to you by another medical practitioner? If so, please provide the name and contact details of the referring doctor:
Have you referred the patient to any other doctor? If so, please provide the name and contact details of the doctor you have referred them to:

If the condition is related to a pregnancy, please confirm the following:			
Date of last menstrual period:			
Date pregnancy was confirmed:			
Estimated date of delivery:			
Expected delivery type:			
Is the pregnancy a result of assisted reproduction/IVF?	Yes ☐	No ☐	
Has the patient ever been pregnant before? How many times?	Yes ☐	No ☐	Number of previous:
Has the patient any previous pregnancy related complications?	Yes ☐	No ☐	
Is the pregnancy considered to be high risk?	Yes ☐	No ☐	

I hereby certify that I am currently treating the above named patient for this medical condition and that the information I have provided is correct to the best of my knowledge. I understand that the accuracy of the information provided may affect my patient's claim for private medical treatment.			
Name of Physician:		Telephone:	
Address		Qualifications:	
Signature:		Practice Stamp:	

Completed forms can be either emailed to internationalhealthcare@healix.com or
FAXED to: 011 44 20 8481 7826