CLAIM FORM

PLEASE COMPLETE THIS FORM IN BLOCK CAPITAL LETTERS USING BLACK INK

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 phone consultation. If you are requesting a letter of guarante for each procedure from our Singapore Office please provide them your current email address and number.

PLEASE COMPLETE A NEW/SEPARATE CLAIM FORM FOR EACH:

☐Patient ☐Hospital admission or day surgery ☐Medical condition ☐Currency

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

CLAIMANT DETAILS

Full name: **Title: Mr/Mrs/Miss/Ms/Dr**

Policy number: **Sex: ☐ Male ☐Female**

Email: **Date of birth:**

Mailing address:

Telephone: **Fax:**

Please state the name and address of your usual doctor (which may not necessarily be the one treating you for this claim):

Name:

Address:

Telephone: **Fax:**

Email:

Do you have any other insurance policy (eg. Medical, Travel, Life, Accident) that might cover this cost (in all or part)?

☐NO ☐YES, I have insurance cover with: **Phone:**

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?

Is further treatment planned or expected?

Have you ever suffered from this or any related condition before? ☐YES ☐NO If yes, when?:

Is your claim related to injuries sustained in an accident? ☐YES ☐NO If yes, please provide details of the accident and injuries sustained:

SECTION B - Payment details and declaration

PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the original, fully itemized bills. We cannot accept copies. For pharmacy, laboratory or radiology charges please make certain the specific drugs or tests involved are detailed/listed and any doctor's prescription included.

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

WHO WOULD YOU LIKE US TO PAY?

☐ **My Doctor/Hospital** ☐ **Myself**

YOUR BANK ACCOUNT DETAILS IF YOU WOULD LIKE US TO PAY YOU

Bank Name: **Name as per bank account:**

Block/Building: **Account Number:**

Street: **Swift Code (Compulsory):**

Zip Code & City: **IBAN (Europe bank only):**

Country: **Currency of Account:**

DECLARATION & AUTHORISATION

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 authorize any doctor of medicine, hospital or other person who has attended or examined me, to furnish Vivilate or their authorized representative, any and all information they may have with respect to the assessment or treatment of my past or current medical conditions, including if required copies of all original hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian).

I also authorize Vivilate to communicate with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s.

Print name:

Signature: **Date:**

Relationship to patient if not the patient:

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

PRACTITIONER'S DETAILS

Your Name: **Qualification:**

Address:

Phone: **Email:**

PATIENT DETAILS

Patient's 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:

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?

YOUR DIAGNOSIS

What is your clinical diagnosis?

Please advise tests performed and attach test results:

WHAT IS YOUR TREATMENT PLAN FOR THIS PATIENT?

Please mention any pharmacy prescribed or plans for any surgical procedure or operation:

Has the patient refused any treatment recommendation from you?

MEDICAL HISTORY

IMPORTANT – IF THIS SECTION IS LEFT BLANK THE CLAIM CANNOT BE PAID

Please answer each of the following questions:

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:

Was the condition caused by an accident: ☐YES ☐NO If yes, please provide details of the accident and injuries sustained:

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?	☐	☐	
Diabetes?	☐	☐	
Asthma, respiratory or allergic conditions?	☐	☐	
Spine, bone, joint or muscle conditions?	☐	☐	
Cancer?	☐	☐	
Psychiatric, psychological or mental disorders?	☐	☐	
Any other disease or injury requiring in-patient treatment?	☐	☐	

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, true and complete and provide all relevant detail for assessment of this claim.

Doctor's Signature: **Date:**

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP

SEND YOUR COMPLETED CLAIM FORM TO:

Safe Meridian Claims Team
10 Chang Charn Road, #04-01
Singapore159639

- Please ensure that all sections of the claim form are fully completed.
- Claims payment may be delayed if all sections of the claim form are not completed in full.
- The form should be returned to us within six months of the initial treatment date.
- Always enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable.