Evolution Health Claim Form

morganprice international healthcare
global thinking, personal care

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim. Any claim form which has not been fully and properly completed cannot be processed and will be returned for completion
- Please complete Page 1 and 2 of this document and ask your treating doctor to complete Page 3. Please note that any fee charged for completing this section is your responsibility;
- Once your claim form has been fully completed you should send it to us together with all supporting information and bills. You have the choice of either;
    1. scanning these documents and sending them by email to: morganprice@intana-assist.com If you choose to do this then please ensure that all documents are clearly scanned - don't forget to scan both sides of a document if appropriate.
    2. faxing the documents to us on +44 (0) 1444 45 73 56. Please note: If you choose to send your claim to us by email or fax you must still post all of the original documents to us at the address given below.
    3. posting the original documents to us at Morgan Price Claims, c/o Intana, PO Box 637, Haywards Heath, West Sussex RH16 1WR, England, UNITED KINGDOM

  Whichever method you choose to send in your claim, we recommend that you keep copies of all documents that you send to us should you require them at a later date.
- A separate claim form is required for every patient and each medical condition;
- If you know in advance that you are being admitted to hospital on either an in-patient or day-care basis or require transportation then you must obtain our pre-authorisation before incurring any such expenses otherwise if you go ahead without our approval a co-insurance of 25% of the eligible costs incurred will apply to your claim.
- Finally we kindly ask that you complete this form in **BLOCK CAPITALS**, and remember that you must submit your claim form together with all supporting invoices and documents **within 6 months of the treatment date otherwise it will not be considered.**

IMPORTANT: IF THIS CLAIM IS A CONTINUATION OF A PREVIOUS CLAIM WITH MORGAN PRICE, OR FOR A CONDITION WHICH YOU HAVE CLAIMED FOR BEFORE, PLEASE TICK HERE [ ] AND PROVIDE DETAILS ON A COVERING SHEET.

1. Policyholders Details

Policy Number (Must be completed)		Title	
Surname		First Name(s)	
Correspondence address			
		Postcode	
Phone No. (Daytime)		(Evening)	
Mobile Phone No.		Fax	
Email			

2. Patients Details

Title		Surname		First name(s)	
Date of Birth (dd/mm/yy)	/ /	Is this claim related to an accident?		Yes	No
		Is a claim to be made against a third party? If YES please provide full details below.		Yes	No

Please provide full details

Are the expenses recoverable either in whole or in part from any other source or insurance policy? If YES please provide full details below. Yes No

Please provide full details

3. Payment Details

Option 1 Payment to Policyholder/Insured

Payment to be made in: Invoice currency Other currency (Please specify)

We can settle claims in most major world currencies but in a few cases where we cannot settle in your required currency then we will pay you in the same currency as your premiums are paid.

Please indicate your chosen method of payment by ticking the relevant box:

Bank/Wire Transfer Please complete bank details below

Name of bank account

Account no. / IBAN Sort/branch code

Swift Code Bank Name

Bank Address

Credit Card (Mastercard or VISA only) OR Debit Card Please complete details below

Card Type Mastercard Visa Debit Card

Card Number

Expiry Date Month Year Name on Card

Cheque OR Foreign Draft

Option 2 Payment to Provider of Medical Services (e.g. Hospital, Specialist, MRI)

Please tick if Direct Billing has been previously agreed with Intana / Astrenska Insurance Ltd

4. Patient Signature and Release

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Morgan Price International Healthcare Ltd, Intana, Astrenska Insurance Ltd, or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient signature Date (dd/mm/yy) / /

SECTIONS 5 & 6 MUST BE COMPLETED IN EVERY CASE, BY THE TREATING DOCTOR, PHYSICIAN OR CONSULTANT.

TO BE COMPLETED BY THE TREATING DOCTOR IN **BLOCK CAPITALS.**

5. Medical Provider Information

Name of doctor/specialist	
Qualifications/credentials	
Name of hospital/clinic	
Address	

Post Code		Country	
Phone No.		Fax No.	

Email

6. Medical Information

Has Treatment Authorisation been obtained ? ☐ Yes (please attach details) ☐ No

Indicate type of treatment received ? ☐ Elective ☐ Emergency

Indicate type of condition ☐ Acute ☐ Chronic ☐ Acute episode of a chronic condition

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you? Date (dd/mm/yy) / /

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? Date (dd/mm/yy) / /

Are you aware of any treatment given for this or any related illness in the past? ☐ Yes ☐ No

If Yes, please give details :

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details.

Name of referring physician	
Telephone number	
Date of referral (dd/mm/yy)	

Applicable to dental treatment only

Was the patient suffering from dental pain at the time he/she visited you for treatment? ☐ Yes ☐ No

Doctors Signature	
Date (dd/mm/yy)	/ /

STAMP

The confidentiality of patient and member information is of paramount concern to us. Morgan Price International Healthcare Ltd and Astrenska Insurance Ltd, fully comply with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

Send completed form to: Morgan Price Claims, c/o Intana, PO Box 637, Haywards Heath,
West Sussex, RH16 1WR, England
Claims Helpline +44 (0) 844 338 5858 Fax +44 (0) 1444 457356 E-mail morganprice@intana-assist.com