Evolution Health Plan

morganprice international

Claim form

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 **sections 1 - 5** of this document and ask your treating doctor to complete **sections 6 - 7**. Please note that any fee charged for completing these sections is your responsibility.
- 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-patient 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**.

Send your form with all supporting information and bills

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.

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.

+44 (0) 1444 45 73 56

Fax your documents to us.

United Kingdom

Post the original documents to:
Morgan Price Claims, c/o Intana
PO Box 637, Haywards Heath
West Sussex RH16 1WR

1 Claim details

Is this a claim a continuation of a previous claim with Morgan Price, or for a condition which you have claimed before? Yes ◯ No ◯

If yes, please provide details on a covering sheet.

2 Policyholders details

Policy number

Title | Forename(s) | Surname

Correspondence address | Post/Zip code

Phone | Mob | Fax | Email

3 Patient details

Title | Forename(s) | Surname

Date of birth

Is this claim related to an accident? Yes ◯ No ◯

Is a claim to be made against a third party? Yes ◯ No ◯

If yes, please give details:

Are the expenses recoverable either in whole or in part from any other source or insurance policy? Yes ◯ No ◯

If yes, please give details:

4 Payment details

Please select from the options below.

Option 1. Payment to policyholder/insured ◯

Payment to be made in Invoice currency ◯ Other currency ◯

If other please specify

4 Payment details — continued

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 ticking the relevant box:

Bank/wire transfer ◯

Name on bank account | Account no/IBAN

Sort code | Swift code

Bank name | Bank address

Credit card (Mastercard or Visa only) OR debit card ◯

Card type | Mastercard ◯ | Visa ◯ | Debit card ◯

Name on card | Expiry date

Card number

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 ◯

5 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

The following sections are to be completed by the treating doctor in BLOCK CAPITALS

6 Medical provider information

Name of doctor/specialist | Qualifications/credentials

Hospital/clinic name | Phone | Fax

Email | Country

Address | Post/Zip code

7 Medical information

Has treatment authorisation been obtained? Yes ◯ No ◯

If yes, please attach details

Indicate type of treatment received Elective ◯ Emergency ◯

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

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?

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition?

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

Phone Date of referral

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

Doctors 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.