

# Medical Claim Form

Please ensure your claim form is fully completed and returned as soon as possible.  
Please note that Goodhealth are not responsible for any fees incurred in the completion of this form or any further information/documents required by us to assess a claim.  
The issuing of this claim form is in no way an admission of liability.



Policyholder

Policy Number

For all out-patient claims under HK\$1,500.00 (US\$200) per condition, please complete Section A, B and C and return this with the original receipt showing the diagnosis and a breakdown of costs. However, all sections must be completed IN FULL for hospitalisation claims and all claims over HK\$1,500.00. A referral letter from your Specialist should be attached when you are claiming for diagnostic tests or covered alternative treatments.

**PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.**

## Section A - Personal Information

Surname

Address

First Name & Initials

Date of Birth

E-mail

Home Telephone No.

Fax/Mobile

Do you hold any other insurance under which you could claim? If yes, please provide details on a separate sheet  Yes  No

## Section B - Claims Settlement

Original Currency

How do you wish settlement to be made?

Amount for Medication

Cheque to Home Address  Cheque to Bank

Amount for Consultations

Bank Transfer (not available in some countries)

Amount for Hospitalisation

Bank Details (Name, address, account number, bank code)

Amount for Other

Total Amount Claimed

Currency in which you require settlement

## Section C - Declaration

"I declare that all information, to the best of my knowledge, provided on this claim form is truthful and correct. I also understand that this declaration gives permission to Goodhealth and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners."

"I declare and agree that the personal information collected or held by Goodhealth Worldwide Limited, whether contained in this form or otherwise obtained may be used by Goodhealth Worldwide Limited, or disclosed or transferred to any organisation within or outside Hong Kong for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment, (3) provide marketing material in respect of insurance related services of Goodhealth Worldwide Limited or its associated companies and (4) process claims or analyse the insurance."

Patient's Signature (if patient is under 18 years, parent or guardian must sign)

Date

## Section D - Claims Information - to be wholly completed by the Medical Practitioner or Dentist as applicable

Condition requiring treatment

Has this condition been suffered from previously?

Underlying cause(s)

Please provide dates of previous consultations/treatment

How long has condition existed?

Please confirm the likely period of treatment

When were symptoms first apparent to the patient?

Please detail the medication/treatment prescribed or that will be prescribed

Address of referring doctor

Was the treatment in respect of an acute exacerbation of a chronic condition?

Please detail any pathology performed and attach the results

Is this a routine check up?  Yes  No

Date of first consultation with any Practitioner of this condition

Please detail the composition of the fillings/crowns (if applicable)

## Declaration - to be completed by the Medical Practitioner/Dentist

Name

Tel

Fax

E-mail

Address

Signature

Date

Official Stamp

### \*\*IMPORTANT\*\* - Please ensure

- 1 - All original invoices and prescriptions are attached
- 2 - The claim form is completed in full
- 3 - The declarations are signed and dated
- 4 - All laboratory test are attached
- 5 - The diagnosis and underlying cause have been confirmed

This will ensure that your claim is reviewed in a timely fashion.