Medical information form

Here to help

+44 (0) 1892 556274

Available day or night, 365 days a year

Please help us to review your claim quickly by writing clearly

There are three parts to this form:

Part	Who needs to complete this part
A: Claim Details	the patient making the claim
B: Patient Consent	the patient making the claim
C: Medical Details	the patient's Doctor or Medical Practitioner

Please send your completed form to:

Upload or secure email via:
axaglobalhealthcare.com/customer

Fax: +44 (0) 1892 508256

Post: AXA – Global Healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent, TN1 2PL, UK

Definitions of words and phrases

Some of the words and phrases we use on this form have a specific meaning, for example when we talk about treatment.

You and your – when we use you and your, we mean the lead member and any family members covered by your policy.

We, us, and our – when we use we, us or our, we mean AXA Global Healthcare (UK) Limited acting on behalf of AXA PPP healthcare Limited.

Part A: Claim details – to be completed by the patient

A1 About you and your claim

Please remember to use **BLACK INK** and write in **BLOCK CAPITALS** throughout

Full name and title

Address

Please give full address details, including postal code and country where applicable.

Membership/customer number

Claim number (if known)

Contact details

Please include country and area codes, where applicable. Please give the Parent or Legal Guardian's details if the patient is under 16.

Telephone

Email

Date of birth

D D M M Y Y Y Y

Reason for claim

Please describe the symptoms or medical condition being treated

Continued on next page

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A2 Claim payment details

Have you already paid any bills for the treatment you're claiming for?

☐ **No** ▶ Please go to **section** A3

☐ **Yes** ▶ Please complete the rest of this section

We'll pay for any treatment you're covered for directly into your bank account.

Please attach all itemised receipted invoices for the treatment as well as any medical certificates, correspondence or documents relevant to the claim.

To avoid any delays with your claim, please make sure you list:

- The dates of the treatment
- The type of treatment
- The medical condition
- The invoice value

Currency for claim to be paid in

IBAN (if relevant to your bank's location)

Country

SWIFT or BIC code

Bank account number

ABA number (if relevant to your bank's location)

Payee name

Bank name and address

Account name

If you have further treatment planned, please contact us on +44 (0) 1892 556274 or online by following the instructions at axaglobalhealthcare.com/customer

A3 Further information

Do you want to claim a cash benefit for treatment received free of charge?

☐ **No**

☐ **Yes** ▶ If yes, please send confirmation of the dates of your stay or treatment with this form and proof that the services were provided free of charge.

Is the treatment following an injury or accident?

☐ **No** ▶ Please go to **Part** B

☐ **Yes**

a. Do you feel that someone else was at fault and caused the accident or injury?

☐ **No**

☐ **Yes**

b. Do you have another insurance policy that would also cover your claim?

☐ **No**

☐ **Yes** ▶ If yes, please give details

Other insurer details

Part B: **Declaration and Consent**

I declare that all the information I have given on this form is correct to the best of my knowledge.

To support the administration of my health insurance arrangements I consent to:

a) AXA PPP healthcare Limited and/or AXA Global Healthcare (UK) Limited (jointly **AXA**) requesting medical and health information from the patient's healthcare practitioner and/or hospital (please see the **Medical Reports** section of this form)

b) the healthcare practitioner and/or hospital providing that health information in reports, or by copies of my health records and medical information, to **AXA**

c) the healthcare practitioner and/or hospital involved in the patient's care reviewing medical information and discharge arrangements with **AXA** for the following reasons: (Please tick yes or no for each of the following)

(a) to assess and subsequently review my claim and apply policy terms/exclusions (if you tick no we may not be able to process your claim)

☐ **Yes**
☐ **No**

(b) to audit healthcare practitioner and hospital records to review their performance and ensure that AXA is being billed correctly

☐ **Yes**
☐ **No**

I declare that I am the patient

☐ **Yes**
☐ **No**

Is the patient under 16 years of age?

☐ **No**
☐ **Yes**

If yes, I declare that I am the patient's parent/guardian

☐ **No**
☐ **Yes**

I wish to see any report from the medical practitioner before it is sent to you

☐ **No**
☐ **Yes**

Signed*
(This form must be hand signed. We do not accept electronic signatures.)

*If the patient is under 16, this form must be signed by their parent/legal guardian

Date

D	D	M	M	Y	Y	Y	Y

Patient's full name

I wish for another person/other organisation(s) to help me with this claim and I agree, for that reason, that **AXA** or any policy administrator and the person/organisation(s) named below may discuss this claim and to the extent necessary disclose to each other my relevant health and medical details.

☐ **No**
☐ **Yes**

If you answered yes please give the name of the person or organisation(s) here:

(if you give names of one or more organisation(s), this will mean that we can communicate with any employee [which will help if the person you usually deal with is not available]).

Part C: Medical information

To be completed by the patient's medical practitioner – please help us by typing or writing clearly

Patient Name

Date of birth

D D M M Y Y Y Y

How long has this patient been known to you?

Are you the patient's usual primary-care physician?

☐ **No**

☐ **Yes**

Do you have access to the patient's medical history?

☐ **No** ▶ See below

☐ **Yes**

If no, please tell us the name and address of the person who holds the patient's medical history file

C1 Medical details

Medical condition / Diagnosis

ICD Code

Surgical Code (if appropriate)

Description of Symptoms

How long have symptoms existed prior to consulting you?

When did the symptoms first start?

D D M M Y Y Y Y

If there are no symptoms, what prompted the patient to see you?

Given the aetiology of the condition, how long do you think the condition has been present?

Date of first treatment or consultation with any provider

D D M M Y Y Y Y

Date of treatment with you

D D M M Y Y Y Y

Type of investigation required to confirm diagnosis

Further treatment plan (if any)

Was the patient referred to you by another medical practitioner?

☐ **No**

☐ **Yes** ▶ If yes, please provide name and contact details of referring medical practitioner

Is the claim related to or as a result of any previous surgery or treatment?

☐ **No**

☐ **Yes** ▶ If yes, please detail, including dates

Continued on next page

C1 Medical details (continued)

Does the patient have any associated or related medical conditions?

- ☐ **No**
- ☐ **Yes** ▶ If yes, please state and explain the relation and date of diagnosis

Has the patient received any previous consultation(s)/ treatment or hospitalisation for this condition or for associated conditions or symptoms?

- ☐ **No**
- ☐ **Yes** ▶ If yes, please detail

Date of treatment

D	D	M	M	Y	Y	Y	Y

Medical condition/treatment

Provider name

Is the patient taking any medication for this condition?

- ☐ **No**
- ☐ **Yes** ▶ If yes, name of drug and date of starting medication

If the claim relates to pregnancy, is the pregnancy a result of natural conception?

- ☐ **No**
- ☐ **Yes**

If the claim relates to pregnancy, is this the patient's first pregnancy?

- ☐ **No** ▶ If no, please detail any previous complications of pregnancy
- ☐ **Yes**

C2 Medical practitioner declaration

I am the patient's medical practitioner and confirm that the information I have provided is correct to the best of my knowledge. I understand that, if any of the information is incorrect, this may affect my patient's claim for private healthcare expenses

Signature

Print name

Date

D D M M Y Y Y Y

Email address

Contact telephone number

Practice Stamp

Medical Reports

If we ask for a medical report with details of your current condition, the history of your condition and any proposed treatment you don't have to give your consent however if you don't give consent we may not be able to process your claim.

If you wish to see the report before it is sent to us please tick the box below. We will write to you to tell you the date we request the report and you must contact the medical practitioner within 21 days of the date of our request. You have 21 days from the date of contacting your medical practitioner to arrange to see it.

☐ I wish to see any report from the medical practitioner and/or hospital before it's sent to **AXA**

If you don't tick the box but then change your mind, you can contact your medical practitioner and ask to see the report.

You can ask the medical practitioner to see the report at any time within six months of the medical practitioner sending it to us.

If you disagree with the information in the report, you can ask the medical practitioner to change it. If the medical practitioner does not agree with you, they will ask you to write a statement to go with the report that is sent to us.

Your medical practitioner does not have to show you parts of the report if they think it could cause harm to your physical or mental health, or if it shows future plans for your care that the medical practitioner doesn't want you to see.

If the report includes information about someone else, the medical practitioner will not show you that part of the report.

Your medical practitioner may charge you for a copy of the report. This charge is not covered by your plan.

If any medical records we receive show that a medical condition should have been declared on your plan application, we may change the terms of your plan.

Data Protection

We'll handle your personal data in accordance with all relevant Data Protection legislation.

You are entitled to see information we hold about you. You can write to us to ask for a copy of any personal information about you in any independent reports we request. If you would like a copy of a medical report that your medical practitioner has sent to us, it will be quickest if you contact them direct because we will have to get their permission to release it to you.

To ensure that we are able to provide the best service to you we process claims in various countries throughout the world.

We may audit the medical records of medical practitioners and hospitals to:

- prevent and detect crime, particularly fraud,
- review the performance of specialists,
- ensure that we are being correctly billed for their services.

Audits may be part of a programme or in response to a specific event.

We may need to share information with third parties including medical experts, other insurers and other organisations concerned with the detection and prevention of fraud.

In certain circumstances we are required by law to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crimes. This may involve adding non-medical information to databases that can be viewed by other insurers and law enforcement agencies. We may also be required to tell relevant regulatory bodies about any issue where we have reason to doubt a medical provider's fitness to practise.

For our full Privacy Policy please see www.axaglobalhealthcare.com/privacynotice

Integrated healthcare for group health schemes

If you're a member of a company healthcare scheme your employer may also provide or use our Occupational Health Service and/or Employee Assistance Programme. These services are provided by separate companies.

With your consent we and these companies will share sensitive and/or personal information, in confidence on an ethical need to know basis to provide you and your employer (in the case of Occupational Health Services and the Employee Assistance Programme), with support and advice about your health.

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