Global Options



Checklist

Please tick to indicate that you have provided us with the following:

- 1. A fully completed Claim Form (including section 7)
- 2. Bank Details Form
- 3. All invoices relating to the treatment received
- 4. Proof of Payment
- 5. If applicable, the letter of referral and/or Medical Report

Please note, if any of the above are either incomplete or missing, your claim will not be processed and the incomplete or missing information will be requested.

Important Notes

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/dentist to complete sections 6 7. Please note, any fee charged for completing these sections is your responsibility.
- A **separate claim form** is required for every patient and each medical condition.
- For continuation Claims A new claim form signed and stamped by your treating physician is required each new policy year. We require an
 update on your health annually with confirmation of the status of the condition and any treatment required.
- Please complete this form in BLOCK CAPITALS, and remember that you must submit your claim form together with all supporting invoices and documents within 3 months of the treatment date otherwise it will not be considered for settlement.
- Pre authorisation is required for all claims relating to in-patient/day-patient treatment and medical evacuation/repatriation benefits.
 Please call +44 (0) 3300 581 668 for approval.

IF YOU GO AHEAD WITHOUT OUR APPROVAL A CO-INSURANCE OF 25% OF THE ELIGIBLE COSTS INCURRED WILL APPLY TO YOUR CLAIM.

- Please complete and submit a Bank Details Form with your first claim so that we can make payment to your nominated bank account.
- If you have a query relating to a claim, you can e-mail us at mpclaims@morgan-price.com or telephone +44 (0) 3300 581 668

By post

Post the original documents to: Morgan Price Claims, 2 Penfold Drive, Gateway 11, Wymondham, Norfolk, NR18 0WZ, United Kingdom.

We recommend that you keep copies of all documents that you send to us should you require them at a later date.



By email

If you choose to submit your claim by e-mail to, then please ensure that all documents are clearly scanned. Don't forget to scan both sides of a document if appropriate.

You must retain the original documents as we reserve the right to request these to process your claim. E-mail: **mpclaims@morgan-price.com**



1 Claim details

ls this a r	new claim?			Yes	No
	continuation of a previous claim with Morgan Price? ease provide a claim number if you have one			Claim No	
Is this a c	laim for which you have obtained pre-authorisation?	Yes	No	Pre-authorisation	No
2	Policyholders details				
	Company Scheme				
Policy nu	mber				
Title	Forename(s)		Surname		
Correspo	ondence address			Post/Zip code	
Phone	Mob	Fax	l Em	ail	1
3	Patient details		C		
Title	Forename(s)		Surname		
Date of b	irth				
Is this cla	im related to an accident?			Yes	No
ls a claim	to be made against a third party?			Yes	No
lf yes, ple	ease give details:				
Are the e	xpenses recoverable either in whole or in part from any	y other source or ins	urance policy?	Yes	No
lf yes, ple	ease give details:				

4 Claim information

a. Please state the nature of the illness/symptoms:	
b. When did the symptoms first occur?:	

c. Have you ever received treatment (including over the counter medication) for this condition or any related condition before this episode?

Yes No If yes, please provide details below:



4 **Claim information** — continued

d. Please list below the invoices you are submitting for reimbursement (Please note, if any of the invoices you submit are unclear, these will be sent back to you):

Date of treatment	Expenses for which reimbursement is required	State the currency and amount paid	To whom should we make settlement*	Currency of accounts

* Please ensure that a Bank Details Form has been provided to us.

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, or their appointed representatives.

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

Patient	signature

Date

6 Dental claims (to be completed by treating dentist)

Name of dentist		Qualifications/credentia	ls		
Dental clinic name	Phone		Email		
Address					
Post/Zip code		C	ountry		
Has the patient been attending regular routine check-	ups?			Yes	No
Date that the patient visited you for treatment:					
Reason for the visit:					
Was the patient suffering dental pain at the time he/s	he visited you for tr	eatment?		Yes	No
Is the treatment for a new filling or a replacement filling	ng?			Yes	No



6 **Dental claims (to be completed by treating dentist)** — continued

In your opinion, has the patient maintained good dental hygiene? If no, please provide details below:	Yes	No
Date of the patient's last check-up:]
Reason for check-up:		
Dentist signature	Date	1

This section must either be typed or completed in BLOCK CAPITALS.

7 Medical information (to be completed by treating physician)

Name of doctor/specialist		Qualifications/cre	Qualifications/credentials		
License Number		Governing Body			
Hospital/clinic name	Phone		Email]	
Address]	
Post/Zip code			Country		
Indicate type of treatment received			Elective	Emergency	

ICD code:

Please provide full details of the medical condition requiring treatment and the treatment given.

Was this their first visit to you? If yes, were they referred to you? If yes, please provide details of the person referring them.

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



7 Medical information (to be completed by treating physician) — continued

For out-patient psychiatric treatment, please provide the following details:

Name of referring physician

Date of referral

Doctors signature

Phone

Date

Doctors/Dentist stamp

The confidentiality of patient and member information is of paramount concern to us. Morgan Price International Healthcare Ltd, their insurers and appointed representatives, 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.