AXA PPP healthcare

Atlas Healthcare

Claim form

Please send this form to Atlas Healthcare Insurance Agency Ltd – Abate Rigord Street, Ta' Xbiex XBX 1121, Malta. Do not forget to attach original accounts (bills or receipts) where applicable. **PLEASE FILL IN ALL DETAILS** and use BLOCK capitals throughout.

Policy number Group (where applicable)

Making a claim/Biex tagħmel "Claim"

Please follow these instructions carefully to ensure that your claim will be processed efficiently and without any need for further clarification.

1. Claims for specialist consultations and any diagnostic procedures must be referred by your general practitioner.
2. Your general practitioner must fill in Part A of the Medical statement and the specialist referred by the general practitioner must fill in Part B of the same statement.
3. Claims should be submitted within 2 months of the date of treatment **and must include an itemised list of all tests carried out (including blood tests).**
4. Contact Atlas Healthcare Insurance Agency BEFORE receiving in-patient or daycare treatment (i.e treatment which requires admittance to a hospital or clinic even if only for a few hours) or before a bone density scan, a mammogram, home nursing, a CT or MRI scan or psychiatric treatment. We will confirm the extent of your cover and put your mind at rest as to how your cover applies to the hospital or specialist you have chosen.
5. We recommend that you photocopy the completed form and any enclosures for your records.
6. We are unable to accept original receipts where alterations have been made unless such alteration is signed by the person issuing the receipt.

Jekk jogħgbok segwi dawn l-istruzzjonijiet sew biex nkunu nistgħu nipproċessaw il-"claim" tiegħek mill-iktar fis u biex ma jkollniex bżonn iktar kjarifiki.

1. Claims għal konsultazzjonijiet ma' speċjalisti u testijiet għandhom dejjem ikunu referuti mit-tabib tiegħek.
2. It-tabib tiegħek irid jimla l-ewwel parti (Parti A) tal-"Medical statement" u mbagħad l-ispeċjalista jimla t-tieni parti (Parti B) ta' l-istess "Medical statement".
3. Il-claims għandhom jintbagħtu għandna fi żmien xagħrejn mid-data ta' meta mort għand it-tabib jew ħadt it-trattament jew testijiet u **ma' kull claim għal testijiet tad-demm għandha tintbagħat lista tat-testijiet li saru.**
4. Ċempel lil Atlas Healthcare Insurance Agency QABEL ma tidħol l-isptar anki għal xi siegħat biss; jew qabel ma tagħmel “bone density scan”, qabel ma ġġib ners għal trattament id-dar jew tmur tara psikjatra. Aħna nkunu nistgħu nikkonfermawlek kif tkoprik il-polza tiegħek u kemm nħallsu għall-isptar jew l-ispeċjalista li tkun għazilt.
5. Nirrikmandaw li żżommu kopji tad-dokumentazzjoni kollha li tibagħtulna.
6. Ma nistgħux naċċettaw irċevuti fejn l-ammonti ġew mibdula mingħajr firma ta' min ħareġ l-irċevuta.

1. Subscriber's details

Full name Identity card number

Address

2. Patient's details

To be completed whether the patient is the subscriber or not.

Full name Patient's identity card number

Date of birth Relationship to subscriber Occupation

Telephone number Mobile number Email address

Reason for seeking medical advice

Is this the first claim for this condition? Yes ☐ No ☐ Date patient first aware of symptoms

Is this claim the result of any accident? Yes ☐ No ☐ If yes give details

Is this claim claimable from any other source (ie another insurance company)? Yes ☐ No ☐

I declare that to the best of my/our knowledge and belief the statements made on this form are true and complete.

Data Protection Declaration

AXA PPP healthcare implement strict controls over electronic and manual personal data. Please read this declaration before signing the claim form to understand how your data may be processed.

I consent to the processing of my personal data by AXA PPP healthcare limited (the Company), Atlas Healthcare Insurance Agency Limited and/or by any other subsidiary companies of Atlas Holdings Limited (Atlas) or any other members of the AXA Group supplied by myself as long as this processing relates to administering my insurance policies; underwriting; handling and settling of claims; detecting, preventing and suppressing of fraud and the keeping of statistics.

I authorise the Company to seek any medical information relating to myself or my dependents. I also authorise any doctor, hospital, laboratory or other health insurance provider to provide full medical information concerning myself or my dependents. I authorise the Company, in addition, to disclose personal information to others (including the Malta Insurance Association, other insurance companies or persons acting on their behalf and/or instructions, the Malta Association of Credit Management (MACM), banks for payment purposes and other appointed experts, together with the Commissioner of Police or any person, body or authority authorised by law to receive personal data) and such others to disclose relevant personal data to the Company or Atlas for the prevention of fraud.

I authorise the Company or Atlas to keep me informed of their products and services by mail, fax, email or other electronic means. I understand that I may inform them in writing if I do not wish to receive this information. I also understand that I have the right to request access to my personal data by contacting Atlas Healthcare Insurance Agency Limited in writing. I am aware that the full details of Atlas' Data Protection Policy, updated from time to time may be found on www.atlas.com.mt/Legal/Data Protection.aspx

Patient's signature Date

(Parent to sign if child is under 18)

continued overleaf

3. Payment Details

3a. Request for payment to be made to a person other than the patient aged 18 or over

To be completed ONLY if payment is to be made to a person other than the patient aged 18 years or over

I authorise benefit to be paid directly to

Address

Signature of patient if aged 18 or over/Subscriber if patient aged under 18 Date

3b. Request for payment to be credited directly to a Malta bank account

☐ I request benefit to be paid directly to bank branch

Bank account number (IBAN)

In the name of I understand that future claim payments in respect of this patient will be credited to this account unless otherwise specified.

Please send notification of payment to the following email address:

Signature of patient if aged 18 or over/Subscriber if patient aged under 18 Date

☐ Please reverse my previous instructions to credit a bank account for claims in respect of this patient and issue cheques for this and any future claim payments. Client's signature

4. Medical statement

Part A – To be completed by your general practitioner BEFORE your visit to the specialist.

Date of first consultation for this condition Date patient first aware of symptoms

Medical history of condition including details of previous treatment

Treatment given

GP declaration

I have examined the patient on and I declare that I am unable to provide the necessary further treatment and I am therefore referring the patient to the following specialist:

Specialist referred to by GP

Signature Date Stamp Telephone number

Part B – To be completed by the specialist referred by your general practitioner.

(In cases of paediatrics or gynaecology/obstetrics, the specialist must also complete part A)

Name of patient State procedure code if known

Details of condition

Drugs prescribed

Planned future treatment specifying any relevant dates

Diagnosis

If this section is not completed in full we may require a separate medical report.

Signature Date Stamp Telephone number

Part C – For in-patient and day-patient treatment only.

(please attach original certificate of in-patient stay if cash benefit for state hospital treatment is being claimed)

Hospital

Date of admission Time am/pm Date of discharge Time am/pm

Signature of hospital official Official's position Hospital stamp