GLOBALCARE

Alfalah Insurance

Claim Form (Reimbursement & Pre - Authorisation)

This claim form is not an admission of liability. Please use a separate claim form for each separate admission.

Part I. To be completed by the Policyholder

Important notes

- This form is to be completed by the Policyholder. Please ensure that your signature tallies with the signature that is provided to our Company.
- To enable us to process your claim promptly, please ensure that the form is fully completed.
- We reserve our rights to request additional information or documents if needed.
- If you have any questions regarding this form or any claims matters, please contact at +92-42-111-234-222 or email us at globalhealthcare@alfalahinsurance.com quoting your policy/membership numbers.
- Claims must be submitted along with all supporting documents within 30 days from the date of treatment.
- Send this claim form together with all supporting documents to globalhealthcare@alfalahinsurance.com

Section A - Administrative

Policyholder	
Policy number	

Patient's Details

Patient name	

Date of Birth (D D M M Y Y Y Y) | ID/Passport Number | Nationality

Gender | Plan | Mobile Number

Email Address

Section B - Other Insurer's Details

Do you have other medical plans with other insurance companies? ☐ Yes ☐ No

If "Yes", please state the Policy No., Commencement date and the name of the Insurer.

Policy number	Commencement date	Insurer

Has a claim been submitted with the above Insurers? ☐ Yes ☐ No

If you have answered 'Yes' to either of these questions, please give the name of the related insurance company involved. (Kindly submit a copy of the other insurance company's claim settlement letter/payment voucher):

Section C - Patient/Policyholder's Declaration

I hereby confirm

1. That I authorize the Physician, Hospital/Clinic or any other medical institution to give the information and/or medical record, according to the diagnosis and/or medication treatment which given to me or my family which being as the Insured, and
2. That I authorize Alfalah Insurance Global healthcare and its designated third party administrators; to gather further information/ medical records from the Hospital and /or other parties related to the diagnosis and/or health services provided to me or eligible members of my family which may be required to process the claim in accordance with existing policy and term conditions.
3. That all information on this Claim Form was written truthfully and I hereby agree that this Letter of Authority to be used promptly.
4. That copy of this Declaration is as valid and has power in accordance with the original document.
5. I authorize/do not authorize my Insurance intermediary to discuss medical conditions as necessary with my Insurer or its authorized Insurance intermediary on my behalf.

Patient/Policyholder signature | Date (D D M M Y Y Y Y)

Section D - Documents to be submitted

Please put a tick in the boxes below and submit the mandatory documents. If the mandatory documents are not submitted or partially submitted, your claim will only be processed upon receipt of the full documents. We reserve the right to determine if any of the documents below can be waived. We will notify you or your Financial Consultant if we need to obtain further information from you or other parties to assess your claim.

- ☐ Claim Form which is to be completed fully (original)
- ☐ Original final itemized medical bills
- ☐ Original proof of payment/ payment receipt. (If claiming for a cash benefit, a copy of the final bill is acceptable)
- ☐ Copy of diagnostic test result (Laboratory result, X-Ray, etc.), Inpatient discharge summary report
- ☐ Copy of doctor's prescription for medicines purchased at an external pharmacy
- ☐ Copy of final itemized medical bills and Copy of Settlement letter from Insurer/ Employer (if claiming balances from Alfalah Insurance Company Limited)

Section E - Administrative specific to Reimbursement Claims

Amount claimed

Beneficiary name (IN CAPITAL LETTERS)

Telegraphic bank transfer (Bank details will be required if previously not declared in application form)

Bank account number/IBAN	Name of bank	Bank SWIFT code

Bank address

Payment will be made in the currency defined in your plan unless we agreed otherwise in writing.
In which currency was the treatment originally billed?

Beneficiary's details

Telephone number	Mobile number

Email address

Part II - To be completed by the Medical Practitioner

Important notes

- Part II of this form is to be completed by the Medical Practitioner.
- To enable us to process the Life Assured's claim promptly, please ensure that the form is fully completed.
- We reserve our rights to request additional information or documents if needed.

Section F - Medical Section (Section F. to be completed by Dentist)

Duration of illness	Date of consult D D M M Y Y Y Y

Complaint & main symptoms

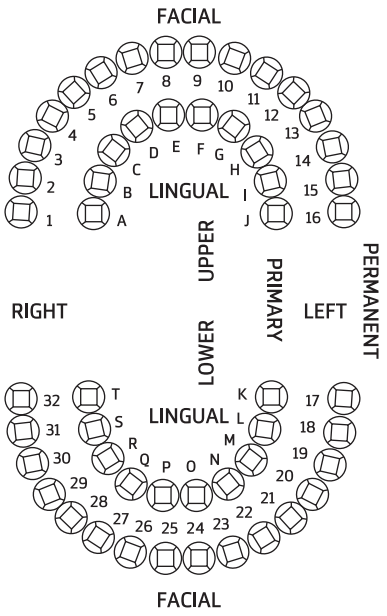
Diagnosis

Other conditions

Please tick where appropriate

- ☐ Routine Check-up
- ☐ Congenital/Development
- ☐ Work Related Accident
- ☐ Road Traffic Accident
- ☐ Orthodontics
- ☐ Aesthetics/cosmetic
- ☐ Sports Related

Please describe how Accident occurred? State date/ time of the Accident and Cause of Accident.



Section F - Medical Section (Section F. to be completed by Dentist) (continued)

Specify the recommended investigation, and or procedures using the tooth number as shown on the teeth map above

Service code	Service description	Tooth no.	Service cost

Section G - Medical Section (Section G. to be completed by Medical Practitioner)

Symptoms presented

Date the patient first became aware of any signs or symptoms for this condition D D M M Y Y Y Y

Date on which the patient first presented to any doctor for this condition D D M M Y Y Y Y

Physical findings

Vital signs	Pulse	BP	Temp	Resp

Provisional diagnosis/condition

Final diagnosis

If there are symptoms presented, please advise

a) How long has the symptom existed prior to consulting you?

b) When did the symptoms first start?

If there is no symptom presented, what prompted the patient to see you?

In your expert opinion, given the etiology of the condition, how long do you think the condition has been presented?

Investigation (describe necessary investigation requested/required to define the diagnosis)

Was the patient referred to you by another Medical Practitioner? ☐ Yes ☐ No
If "Yes", please provide the name of referring Medical Practitioner & contact details.

Does the patient have any related medical condition? ☐ Yes ☐ No
If "Yes, please state and explain the relation.

Does the patient suffer from other significant medical condition(s)? ☐ Yes ☐ No
If "Yes, please state the medical condition(s) and the date of diagnosis.

Medical Condition	Date of diagnosis	Treatment given

Section G - Medical Section (Section G. to be completed by Medical Practitioner) (continued)

Has the patient received any previous consultation/treatment/hospitalization for this condition, associated conditions or symptoms and/or other conditions? ☐ Yes ☐ No
If "Yes, please provide details.

Date of treatment	Medical Condition	Name and Address of Doctor

Is the condition/ treatment/ surgery related to any of these? If "Yes", please tick.

☐ Pregnancy or childbirth ☐ Congenital anomaly ☐ Abortion or miscarriage ☐ A genetic or chromosomal disorder
☐ Infertility or sub-fertility condition ☐ Mental or psychiatric condition ☐ Sexually transmitted disease ☐ Cosmetics reason

If claim is related to pregnancy, is pregnancy conceived from natural conception? ☐ Yes ☐ No

Is the medical condition/ injury caused by an accident? ☐ Yes ☐ No
If "Yes", please tick.

☐ Road traffic accident ☐ Work related accident ☐ Others _____

Please describe how Accident occurred? State date/ time of the Accident and Cause of Accident.

Section H - Treatment Advised

Treatment plan

Medicines	Dose	Frequency	Duration

Procedure (please give details of medical procedures if any)

ICD Code	Surgical Code
Estimated hospital costs	Estimated fees for surgeon and anesthetist
Room type	Daily visit estimate (a)
Room per night	Surgery estimate (b)
Total room & all hospital costs estimate	Treating doctor's total estimate cost (a + b
	Anesthetist's estimate cost

Estimated length of treatment (in days)

Section I - Further Treatment plan

Please give details of any further treatment plan

Section J - Medical Practitioner's Declaration

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection with the above condition and that the facts as given above present my opinion of his/her condition. I declare that the information provided on this form is true and accurate and I did not withhold any material information.

Name of Medical Practitioner	Date D D M M Y Y Y Y
Signature of Medical Practitioner	Hospital/clinic stamp