Evolution Health Plan

morganprice international

Claim form

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 that any fee charged for completing these sections is your responsibility.
- A **separate claim form** is required for every patient and each medical condition.
- Please complete this form in BLOCK CAPITALS, and remember that you **must** submit your claim form together with all supporting invoices and documents **within 6 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

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

You must return the original documents as we reserve the right to request these to process your claim.

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.

1 Claim details

Is this a new claim? Yes ◯ No ◯

Is this a continuation of a previous claim with Morgan Price?
If yes, please provide a claim number if you have one

Claim No.

Is this a claim for which you have obtained pre-authorisation? Yes ◯ No ◯ Pre-authorisation No.

2 Policyholders details

Policy number

Title | Forename(s) | Surname

Correspondence address | Post/Zip code

Phone | Mob | Fax | Email

3 Patient details

Title | Forename(s) | Surname

Date of birth

Is this claim related to an accident? Yes ◯ No ◯

Is a claim to be made against a third party? Yes ◯ No ◯

If yes, please give details:

Are the expenses recoverable either in whole or in part from any other source or insurance policy? Yes ◯ No ◯

If yes, please 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:

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

***** 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/credentials

Dental clinic name | Phone | Email

Address

Post/Zip code | Country

Has the patient been attending regular routine check ups? Yes ◯ No ◯

In your opinion, has the patient maintained good dental hygiene? Yes ◯ No ◯
If no, please provide details below:

Was the patient suffering dental pain at the time he/she visited you for treatment? Yes ◯ No ◯

Dentist signature | **Date**

7 Medical information (to be completed by treating physician)

Name of doctor/specialist | Qualifications/credentials

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

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 ◯

If yes, please give details:

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

Name of referring physician

Phone | Date of referral

Doctors signature | **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, and Arma Insurance Company Ltd, 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.