

# EMERGENCY CLAIM FORM



In accordance with the Health International Terms & Conditions, as stated in the Membership Guide Section 10, any Member visiting a medical facility for the purpose of EMERGENCY treatment is required to do the following:-

- A. **NOTIFY THE REGIONAL OFFICE WITHIN 72 HOURS OF THE EVENT** (by telephone / email / text / visit).
- B. **COMPLETE THIS EMERGENCY CLAIM FORM AND SUBMIT TO THE CLAIMS DEPARTMENT** (see details below).
- C. **MEMBERS ARE REMINDED THAT SHOULD THIS CASUALTY VISIT BE A NON-EMERGENCY / OUT-PATIENT CLAIM, IT MAY BE DECLINED. IF YOU ARE UNSURE, KINDLY CALL THE CLAIMS DEPARTMENT** (See numbers below).

Failure to comply with the above will lead to repudiation of the claim.

## MEMBERS INFORMATION: (As Per Your Health International Membership Card)

NAME OF PRINCIPAL MEMBER:

CONTACT TELEPHONE NUMBER:

L/LINE:

CELL:

FULL NAME OF PATIENT:

DATE OF BIRTH OF PATIENT:

MEMBERSHIP NUMBER:

MEMBERSHIP EXPIRY DATE:

## COMPLETION OF THIS SECTION IS COMPULSORY:

REASON FOR EMERGENCY VISIT: Please Tick The Applicable Box

ACCIDENT

ILLNESS

DATE OF EMERGENCY:

TIME OF EMERGENCY:

FULL DESCRIPTION OF THE EMERGENCY:

NAME OF EMERGENCY FACILITY:

NAME OF TREATING DOCTOR OR SPECIALIST:

(PLEASE INCLUDE CONTACT DETAILS IF AVAILABLE)

## INVESTIGATIONS RELATED TO THE EMERGENCY:

RADIOLOGY (X-RAY / MRI SCAN / C.T. SCAN ETC.)

YES

NO

PATHOLOGY (BLOODS / SPECIMEN URINE / STOOL ETC.)

YES

NO

MEMBER'S SIGNATURE:

DATE:

PLACE:

I understand that Health International will collect and process my personal data as per Clause 9.9 of the Terms and Conditions.



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