HEALTH CLAIM

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health Care (Fiji) Limited, Ground Floor, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: (679) 331 7000 Call Centre: 132 700 Facsimile: (679) 330 8955 Web: www.bsplife.com.fj

PLEASE READ THESE NOTES

- Please complete this form in full. If Medical Provider's Statement is required please ensure that your medical provider completes and submits it to BSP Health.
- Please provide Medical Report and/ or estimation of costs for all claims.

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

A. POLICY OWNER DETAILS

Policy Number _____ Policy Type ☐ Value Health ☐ Premier Care ☐ Premier Plus

Title	First Name	Middle Name	Last Name

B. CLAIMANT'S DETAILS (If different from Policy Owner)

Title	First Name	Middle Name	Last Name

Relationship to Policy Owner _____

C. CONTACT DETAILS

Postal Address

Post Office Box	Street Address	Suburb/Region	Town/City/District

Home Phone Number	Work Phone Number	Mobile Number	Facsimile

Email Address _____

D. ENTITLEMENTS

Do you have any entitlement to worker's compensation or third party insurance in respect of any terms of this claim or other damages?

☐ No ☐ Yes ▸ *If Yes, please indicate under which entitlement:*

E. PATIENT/ SERVICE INFORMATION

Please complete the Section applicable to your claim. As some conditions require prior approval from BSP Health, you are required to complete Section E3 below. If you are making a claim in Section E1 or E3, your medical provider will be required to complete the Medical Provider's Statement which is included in this form and send it to Claims Department, BSP Health (Fiji) Limited, Private Mail Bag, Suva. Benefit payments for dependents aged 18-24 are only payable if they are full time students attending an accredited educational institution.

1. Hospitalisation/Cash Allowance Claims

Name of Insured	Date Patient Hospitalised	Date Patient Discharged	Treatment Received and Condition being Treated or Consulted for	Date of Illness (1st symptom) or Injury (accident) or Maternity Services	Date First Consulted Doctor/ Services Provider	Name & Contact of Doctor/ Service Provider	Account Paid	Fee Charged
eg. John Doe	00/00/14	Angina	00/00/14	00/00/14	00/00/14	Dr Ram, Lautoka Hospital	Yes/No	$2,000

2. **Outpatient Claims** (All reimbursements claims must have original invoices or receipts attached)

Name of Insured	Type of Service	Treatment Received and Condition being Treated	Name of Doctor/ Service Provider	Amount Paid	Date of Treatment
e.g. John Doe	Dental/Optical/Allied Services or Others	Consultation for glasses	Praneel Asgar	$25.00	00/00/14

3. **Prior Approval** (Local Public Hospital, Local Private Hospital, Overseas Hospital)

Please tick the appropriate box	Diagnosis (enclose medical report/ history)	Date of Illness (1st symptom) or Injury (Accident) or Maternity Services	Name of Referring Doctor	Date First Consulted Referring Doctor	Treatment Required
Example	Tonsillitis	00/00/2014	Dip Chand	00/00/2014	Surgery to remove tonsils
☐ Local Public Hospital					
☐ Local Private Hospital					
☐ Overseas Hospital					

F. PAYMENT DETAILS (Payment will only be made if premium payments are up to date)

Bank Name	Bank Account Number	Bank Account Name

G. AGENT'S AUTHORITY

If you want another person, including your authorized Sales Advisor/Broker to make the claim on your behalf, please complete the authoritybelow. Both you and your Sales Advisor must sign prior to lodging the claim. Your sales agent will be asked to provide personal identification.

Claimant	Signature:	Date: DD/MM/YYYY
		Signed at:
	Name in Full:	Date: DD/MM/YYYY

H. DECLARATION (to be signed by the claimant)

I declare that this claim is for the services received to me and/or my nominated dependent(s), or where prior approval is being sought, is for services referred by a registered medical practitioner for myself and or/my nominated dependent(s).

I declare that to the best of my knowledge, the information is true and correct.

I authorise BSP Health Care to contact the provider of any service claimed for the clarification of any details relating to this claim.

Signature of Claimant | Date | FOR OFFICE USE ONLY

What you need to attach to your claim

- Itemised accounts and receipts from the doctor/service provider for Hospitalisation/ Cash Allowance claims.
- Itemised accounts and receipts from the doctor/service provider for Outpatient claims.
- Medical report and Prior Approval letter for the prior approval claims.

Please Note

All documents attached to the claim must be originals and will be kept by BSP Health.

- When lodging a claim through the post do not send your membership card. Please present the membership card when lodging a claim in person.
- Benefits are not payable if your premium payments are not up to date.
- BSP Health brochures provide a summary of the main benefits and conditions of your medical policy.

Privacy - Use and Disclosure of the Personal Information.

The privacy of your personal information is important to you. BSP Health will only collect information about you and any others named on your policy that is necessary for the purpose of providing products and services. The information collected may include health information. If the information you give us is incomplete or inaccurate we may not be able to pay your claim. BSP Health may need to disclose your personal information to other parties, such as health care providers and government authorities.

MEDICAL PROVIDER STATEMENT

(To be completed for Hospitalisation/Cash Allowance & Prior Approval Claim and on request by BSP Health Care)
Please ask your Doctor/Service Provider to complete this statement.
BSP Health Care (Fiji) Limited is NOT liable for any charges levied by your Physician for providing this statement.

1. Patient's Name

2. Patient's Date of Birth DD/MM/YYYY

3. Date of Illness (first symptom) or injury DD/MM/YYYY

4. How long have you known the patient?

5. Date patient consulted you for this condition: First Consulted DD/MM/YYYY Last Consulted DD/MM/YYYY

6. List all the dates on which the patient has consulted you for this condition.

Date	Treatment Received	Date	Treatment Received

7. Objective Findings (Give details of X-Ray, ECGs or other tests)

8. Is this condition a recurrence? ☐ No ☐ Yes

9. Has the patient required surgery, treatment, investigations for this or a similar condition before? ☐ No ☐ Yes ▸ *If yes, please provide details.*

Date	Injury or Illness	Details

10. Are there any other conditions affecting recovery from the current condition? ☐ No ☐ Yes ▸ *If yes, please advise nature or conditions and how they affect recovery?*

11. Was this illness or injury an emergency? ☐ No ☐ Yes

12. Date patient able to return to work

13. Name of referred Physician

14. Hospitalisation Dates From: To:

15. Name and Address of facility where treatment services rendered

16. Diagnosis or Nature of illness or injury (Please indicate primary and secondary)

17. Procedures, medical services & suppliers provided

Date of Services	Place of Service	Description of Service	Charges	Number of Days	Diagnosis Code	Office Use Only
DD/MM/YYYY			$			
			$			
			$			
			$			
			$			

20. Medical Provider's Name

Postal Address:

Telephone: Facsimile: Email:

Medical Provider's Signature: Date

DD/MM/YYYY

Registration No.: Stamp:

INSTRUCTION TO HEALTH CARE PROVIDER

Please send the "Medical Providers Statement" in an envelope marked "CONFIDENTIAL" and addressed to:

The Claims Manager
BSP Life (Fiji) Limited
Private Mail Bag
Suva, Fiji.

Call Centre: 132 700 | 24-hour Health Care Help Desk (679) 326 1787 | Fax: (679) 3308340 | Mobile: (679) 702 4507