HEALTH REIMBURSEMENT CLAIM FORM

Outpatient/Optical and Dental/Allied Services

Please submit completed form and supporting documents to:
BSP Health Care (Fiji) Limited, Ground Floor, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: (679) 331 7000 Call Centre, 24-hour Health Care Help Desk (679): 326 1787 Facsimile: (679) 330 8955 Website: www.bsplife.com.fj

Reset Form

PLEASE READ THESE NOTES:

- Please complete this form in full for reimbursement claims for Outpatient, Optical and Dental and Allied Services.
- Please check to ensure the benefit you are making the reimbursement claim for is stated on your medical card.

SECTION A: POLICY DETAILS
Policy Number:

SECTION B: POLICY OWNER DETAILS *(same details on the medical card)*		
1. Personal Details:		
Title:	First Name:	Middle Name:
Last Name:		Date of Birth:
2. Bank Details: *For efficiency, BSP Health Care (Fiji) Limited makes payments by Electronic Funds Transfer directly into your nominated bank account. Please advise BSP Health Care (Fiji) Limited for any changes to your nominated bank account details.*		
Bank Name:		Bank Account Number:
Bank Account Name:		

SECTION C: CLAIMANT DETAILS *(same details on the medical card)*		
1. Personal Details:		
Title:	First Name:	Middle Name:
Last Name:		Date of Birth:
2. Contact Details:		
Work No:	Home No:	Mobile No:
Email Address:		Alternate Email Address:

SECTION D: CLAIM INFORMATION

Outpatient/Optical and Dental/Allied Service Claims *(All reimbursement claims must have invoices or receipts attached)*

Name of Claimant	Type of Service	Treatment Received and Condition being treated	Name of Doctor/Service Provider	Amount Paid	Date of Treatment

SECTION F: DECLARATION – IMPORTANT, PLEASE READ CAREFULLY

I **declare** that this claim is for services received by me and/ or my nominated dependent(s), for services referred by a registered medical practitioner for myself and or/my nominated dependent(s).

I **declare** that the information provided in this form is true and complete.

I **authorise** BSP Health Care (Fiji) Limited to obtain all necessary medical and other information from any service provider to process this claim.

I **agree** to reimburse BSP Health Care (Fiji) Limited in full if the claim is paid incorrectly and indemnify BSP Health Care (Fiji) Limited for payments made incorrectly to a third party authorised by me.

Signature:	Date:

IMPORTANT INFORMATION

What you need to attach to your claim:	**Please note:**	**Privacy – Use and Disclosure of the Personal Information.**
• Itemised accounts and receipts from the doctor/service provider for Outpatient/Optical and Dental/Allied Services claims.	• All documents attached to the claim will be kept by BSP Health. • When lodging a claim through the post do not send your medical card. Please present the medical 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	The privacy of your personal information is important to us. 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, or obtain from, other parties, such as health care providers and government authorities.