Health Insurance CLAIM FORM

Elmo INSURANCE

Important notes

Please return this form with original invoices, receipts and a copy of test results to:
Elmo Insurance Ltd, Abate Rigord Street, Ta' Xbiex XBX 1111, Malta.

Please ensure that block capitals are used and that all sections of the claim form are fully completed to minimise any delays in handling your claim. Claims are to be submitted within three months of the initial treatment date.

Specialist consultations must be on the initial recommendation of your General Practitioner. A new claim form must be completed for each patient and for each medical condition.

Pre-authorising treatment
You must always contact Elmo Insurance Ltd. before receiving any in-patient / day-patient treatment or a CT / MRI scan to enable us to confirm eligibility.

If you have any questions when completing this form please call us on **2343 0000** or e-mail us on health@elmoinsurance.com

1. Policyholder's details – To be completed by the Policyholder

Policy number		Company name (if applicable)	
Name and surname		ID number	
Address		Telephone number	
		Mobile number	
		E-mail address	

2. Patient's details – To be completed by the Patient undergoing treatment

Name and surname		ID number	
Date of birth		Mobile number	

Reason for seeking medical advice

Date patient first became aware of symptoms/condition?

Is this the first claim for these symptoms/condition?	Yes		No	
Is this claim the result of any accident?	Yes		No	
Are any of the costs recoverable from a third party, such as another insurance policy?	Yes		No	

If 'yes' please give details

3. General Practitioner – To be completed by the General Practitioner

Patient's name and surname

How long have you been the General Practitioner of this patient ?

Details of condition, symptoms and diagnosis

Date patient first became aware of symptoms/condition / /

Date of first consultation for these symptoms/condition / /

Drugs/treatment prescribed

What other treatment/medication is patient currently taking?

General Practitioner's signature and stamp

Details of specialist to whom patient has been referred

Telephone number

Date / /

4. Consultant specialist – To be completed by the Specialist referred by the General Practitioner above

Patient's name and surname

Details of condition, symptoms and diagnosis

Date patient first became aware of symptoms/condition / /

Date of first consultation for these symptoms/condition / /

Specialist's signature and stamp

Drugs/treatment prescribed

Telephone number

Date / /

5. Data Protection Notice

I consent to the processing of my personal data by the company or any other members of the group supplied by myself as long as this processing relates to administering my health insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and the keeping of statistics. I authorise the company to seek any medical information relating to myself or my dependants. I also authorise any doctor, hospital, laboratory or other health insurance provider to provide full medical information concerning myself or my dependants. I understand that the company may, in addition, exchange information with others (including the Malta Insurance Association or other insurance companies) for the prevention of fraud. I authorise the company to keep me informed of its products and services by mail, e-mail or other electronic means. I understand that I may inform them in writing if I do not wish to receive this information. I also understand that I have the right to request access to my personal data by contacting Elmo Insurance Ltd. in writing.

6. Declaration

I declare that to the best of my knowledge and belief, the statements and information given are true. If the information given on my behalf in Sections 3 and 4 of this claim form is insufficient for the company's purposes, I consent to the company obtaining a medical report from my Specialist or General Practitioner and contacting any person or organisation involved in my treatment. I understand that by consenting, I am permitting Elmo Insurance Ltd. to use the information in the form and the medical report together with any extra information gathered during the claims process for the purposes of processing the claim or for other purposes permitted by law. I understand that without this consent Elmo Insurance Ltd. may not be able to process this claim.

I also agree that a copy of this consent shall have the validity of the original claim form.

7. Patient's signature – Parent or guardian if patient is under 18 years

Signature

Date / /