

GLOBAL HEALTH

MATERNITY CLAIM FORM



WILLIAM RUSSELL
Peace of mind wherever you are

PLEASE NOTE: General claims and claims for dental treatment must be made on their own claim forms which are available at www.william-russell.com or by calling +44 1276 486455.

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY.

SECTION A & B MUST BE COMPLETED BY THE PATIENT, OR BY THE PATIENT'S GUARDIAN OR LEGAL REPRESENTATIVE.

SECTION C MUST BE COMPLETED BY THE TREATING DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE DOCTOR.

ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

SECTION A – To be completed by the patient or the patient's guardian or legal representative

1. CLAIMANT DETAILS

Full name of Global Health policyholder: _____ Title: Mr/Mrs/Miss/Ms/Dr

Full name of patient (if not the policyholder): _____ Date of birth: _____

Global Health plan policy number: _____ Sex: Male Female

Full mailing address: _____

Telephone: _____ Fax: _____ Email: _____

Please state the name and address of your personal physician (General Practitioner)

Name: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

2. DETAILS OF YOUR PREGNANCY

On what date did you discover that you were pregnant? _____

Please provide the name of the medical professional that confirmed that you are pregnant: _____

Please confirm how many previous pregnancies you have had: _____

At which hospital do you plan giving birth? _____

Do you plan giving birth by Caesarean Section? YES NO

SECTION B – Payment details and declaration

1. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the original, fully itemised accounts. We cannot accept copies.

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Please state currency and amount paid

2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

PAYMENT TO YOUR VISA CARD NB. We can only make payment to a visa card, and payment will be made in your plan currency.

Card number: _____ Name on card: _____ Expiry Date: _____

Address to which card registered (if different from above): _____

PAYMENT TO YOUR BANK ACCOUNT

Bank name and address: _____

Account holder name(s): _____ Bank account number*:

Sort code: _____ BIC Number*: _____ IBAN number*:

* BIC and IBAN details are necessary for all transfers to European bank accounts.

* BIC and bank account number are necessary for all transfers to international bank accounts.

BANK DRAFT Please state currency of bank draft: _____



3. DECLARATION AND AUTHORISATION AND CONSENT BY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover? No, I have no other health insurance cover
 Yes, I have other health insurance cover with: _____

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell Ltd or to their authorised representative any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian).

Signature of Patient or guardian: _____

Date: _____

SECTION C – To be completed by the patient's doctor

1. PATIENT DETAILS

Patient's full name: _____

Date of birth: _____

Was the patient referred to you? YES NO

If YES, please state the name and contact details of the referring doctor: _____

2. DATES

For how long have you known the patient? _____

On which date did the patient first contact you regarding this pregnancy? _____

What is the expected delivery date? _____

What was the date of the last monthly period? _____

3. FURTHER INFORMATION

Please state diagnostic tests performed, the test results and your reason for performing the tests.

Date(s) of treatment	Tests performed	Reason for tests

Are you aware of any complications that may arise during this pregnancy? If so, please provide details: _____

4. MEDICAL HISTORY

Please answer each of the following questions:

Does your patient have a history of any of the following:-	YES	NO	Details and date of onset
High blood pressure, high cholesterol, heart or circulatory disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma, respiratory or allergic conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine, bone, joint or muscle conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other disease or injury requiring in-patient treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has the patient ever received IVF or any other treatment to assist fertility?	<input type="checkbox"/>	<input type="checkbox"/>	_____

5. DECLARATION BY DOCTOR

I declare that I am the patient's treating Doctor, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature: _____

Date: _____

Please print your name and address: _____

Contact telephone number: _____

Fax: _____

Email: _____

Qualifications: _____

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP