AXA INSURANCE PTE LTD
Claims enquiry
AXA Health Customer Care Centre
8 Shenton Way #24-01 Singapore 068811
☏ +65 63089525
@ ops.tpa.sg@asia-assistance.com
Policy/ Product enquiry
Customer Care Centre at Lv1 AXA tower
☏ 1800 880 4888 (within Singapore)
www.axa.com.sg

redefining / insurance

Policy number

GlobalCare Health Plan

Inpatient Claim Form (Reimbursement & Pre - Authorisation)

Part I - To be completed by the Policyholder

Important note:

1. Part I of this form is to be completed by the policyholder. Please ensure that your signature tallies with the signature that is provided to our Company.
2. Please arrange for pre-authorization at least 5 workings days prior to the commencement of the planned Treatment.
3. To enable us to process your claim promptly, please ensure that the form is fully completed.
4. We reserve our rights to request additional information or documents if needed.
5. Claims must be submitted along with all supporting documents within 180 days from the date of treatment.
6. If you have any questions regarding this form or any claims matters, please contact our AXA Health Customer Care Centre at 65-6308 9525 quoting your policy/membership numbers
7. Send this claim form together with all supporting documents to AXA Health Customer Care Centre at 8 Shenton Way #24-01 Singapore 068811 for claims incurred outside of Singapore. For claims incurred in Singapore, please send them by email to ops.tpa.sg@asia-assistance.com

1. Details of Life Assured

Full name of Life Assured

Date of Birth

2. Other Insurance Claims

(a) Do you have other medical plans with other insurance companies? ☐ Yes ☐ No
If "Yes", please state the Policy No., Commencement date and the name of the Insurer.

(b) Is the treatment covered under Workman's Compensation policy? ☐ Yes ☐ No
If "Yes", please state the Policy No., Commencement date and the name of the Insurer.

(c) Has a claim been submitted with the above Insurers? ☐ Yes ☐ No

3. Settlement method (Direct Credit is Mandatory for all Claim Payments up to SGD$10,000.00)

❑ By Direct Credit up to SGD$10,000.00 (without Bank Book/ Bank Statement)

Name of Bank _____

Name of Bank Account Holder (as per Bank Book/ Bank Statement):-

_____

Bank				Branch			Account number to be debited									

Please take note of the following:-
(1) Direct Credit payment takes just 1 working day after claims approval for UOB customers and 3 working days for all other banks
(2) We will Direct Credit into Policyholder/ Trustee/ Assignee's Bank account only
(3) We do not Direct Credit into 3rd party's Bank Account or Joint Account
(4) In the event, if Direct Credit is unsuccessful, we will issue cheque and post to you directly
(5) If a cheque payment is necessary, it will take up to 7 working days after claims approval to be posted out

☐ By Direct Credit > SGD$10,000.00 (please submit a copy of Bank Book/ Bank Statement)

4. Documents to be submitted

Please put a tick in the boxes below and submit the mandatory documents. If the mandatory documents are not submitted or partially submitted, your claim will only be processed upon receipt of the full documents. We reserve the right to determine if any of the documents below can be waived. We will notify you or your Financial Consultant if we need to obtain further information from you or other parties to assess your claim.

- ☐ Inpatient Claim Form
- ☐ Original final itemized medical bills and proof of payment. (If claiming for a cash benefit, a copy of the final bill is acceptable)
- ☐ Copy of diagnostic test result (Laboratory result, X-Ray, etc.), Inpatient discharge summary report
- ☐ Copy of doctor's prescription for medicines purchased at an external pharmacy
- ☐ Copy of final itemized medical bills and Copy of Settlement letter from Insurer/ Employer (if claiming balances from AXA)

Notes:
(1) For Inpatient claim incurred in Singapore, please send all documents by email to ops.tpa.sg@asia-assistance.com
(2) For Inpatient claim incurred outside of Singapore, please send this claim form with original final itemized medical bills, proof of payment and all supporting documents mentioned above to AXA Health Customer Care Centre at 8 Shenton Way #24-01, Singapore 068811

5. Declaration and Authorisation

I declare that:-

1. The information that is disclosed in this claim form is true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted.
2. I am not an undischarged bankrupt and I have committed no act of bankruptcy within the last twelve months or received any notification or adjudication order for bankruptcy made against me during that period.
3. I HEREBY AUTHORIZE any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of the Life Insured _____ of _____ (NRIC No/ Birth Certificate No/ Passport No for foreigner only) to disclose and make available to AXA Insurance such details and records as may be requested by the Company.
4. The AXA Group and AXA Insurance Pte Ltd have a longstanding policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. If I am not a tax resident of the jurisdiction in which the policy, contract or product is issued (a "Cross-Border Transaction"), AXA Insurance and the AXA Group may, in accordance with applicable laws and regulations, disclose to my home country tax and/or other governmental authorities, my identity and certain information concerning the policy or contract that is the subject of this claim and I hereby consent and agree that AXA Insurance and AXA Group, in their discretion, make such disclosure.
5. The information I have provided is my personal data and, where it is not my personal data, that I have the consent of the owner of such personal data to provide such information.
6. By providing this information, I understand and give my consent for AXA Insurance and their respective representatives or agents to:
   i. Collect, use, store, transfer and/or disclose the information, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore) for the purpose of enabling AXA to provide me with services required of an insurance provider, including the evaluating, processing, administering and/or managing of my or our relationship and policy(is) with AXA, and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purposes").
   ii. Collect, use, store, transfer and/or disclose personal data about me, the Life Assured and those whose personal data I have provided from sources other than myself for the Purposes.
   iii. Contact me to share information about products and services offered by AXA that may be of interest to me by post and e-mail and
   ☐ By telephone ☐ By text message ☐ By fax
7. I am happy to receive customer service communication by e-mail instead of hard copies by post. My latest email address and mobile number are stated below.
8. I further agree that this declaration shall form part of my proposed application for the relevant insurance benefits, and a copy of this form shall be treated as valid and binding as if it were the original

Name of Policyholder

NRIC/ Passport No.

Signature of policyholder

Date

*The signature of policyholder should be signed in the same manner as they appear in our records.

Email Address

Mobile No.

Part II - To be completed by the Medical Practitioner at the Policyholder's expense

Important note:

1. Part II of this form is to be completed by the Medical Practitioner.
2. To enable us to process the Life Assured's claim promptly, please ensure that the form is fully completed.
3. We reserve our rights to request additional information or documents if needed.

1. Patient's details

Full name of patient	NRIC/ Passport number	Date of birth
		DD/MM/YYYY

2. Patient's medical details

(a) Medical condition/ Diagnosis

(b) ICD code

(c) Surgical code

(d) Symptoms presented

(e) Date of first time receiving treatment — DD/MM/YYYY

(f) Date of admission — DD/MM/YYYY

(g) If there are symptoms presented, please advise:
(i) How long has the symptom existed prior to consulting you?

(ii) When did the symptoms first start? — DD/MM/YYYY

(h) If there is no symptom presented, what prompted the patient to see you?

(i) In your expert opinion, given the aetiology of the condition, how long do you think the condition has been presented?

(j) Type of Investigation (required to confirm the diagnosis)

(k) Further treatment plan (if any)

(l) Was the patient referred to you by another Medical Practitioner? ☐ Yes ☐ No
If "Yes", please provide the name of referring Medical Practitioner & contact details.

(m) Does the patient have any related medical condition? ☐ Yes ☐ No
If "Yes, please state and explain the relation.

(n) Does the patient suffer from other significant medical condition(s)? ☐ Yes ☐ No
If "Yes, please state the medical condition(s) and the date of diagnosis.

(o) Admitting hospital

(p) Estimated Length of treatment (in days)

(q) Estimated hospital costs

Room Type

Room per night

Total room &all hospital costs estimate

(r) Estimated cost for surgeon and anaesthetist

(i)Daily visit charges

(ii) Surgeon fee estimate

Surgeon/Treating doctor's total estimate (i + ii)

Anaesthetist estimate charge

(s) Has the patient received any previous consultation/ treatment/ hospitalization for this condition, associated conditions or symptoms and /or other conditions? ☐ Yes ☐ No

If "Yes, please complete below.

Date of treatment	Medical Condition	Name and Address of Doctor
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		

(t) Is the condition/ treatment/ surgery related to any of these? ☐ Yes ☐ No

If "Yes", please tick.

☐ Pregnancy or childbirth
☐ Congenital anomaly
☐ Abortion or miscarriage
☐ A genetic or chromosomal disorder
☐ Infertility or sub-fertility condition
☐ Mental or psychiatric condition
☐ Sexually transmitted disease
☐ Cosmetics reason

(u) If claim is related to pregnancy, is pregnancy conceived from natural conception? ☐ Yes ☐ No

(v) Is the medical condition/ injury caused by an accident? ☐ Yes ☐ No

If "Yes", please tick.

☐ Road traffic accident ☐ Work related accident ☐ Others: _____

Please describe how Accident occurred? State date/ time of the Accident and Cause of Accident.

3. Medical Practitioner's declaration

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection with the above condition and that the facts as given above present my opinion of his/her condition. I declare that the information provided on this form is true and accurate and I did not withhold any material information.

Name of Medical Practitioner

Date

DD/MM/YYYY

Signature of Medical Practitioner

Hospital/ clinic stamp