redefining / insurance

Inpatient/Day Surgery Claim Form

Policy No.

AXA INSURANCE PTE LTD
8 Shenton Way #24-01 AXA Tower
Singapore 068811
Customer Care Team #B1-01
1800 880 4888
customer.care.health@axa.com.sg
www.axa.com.sg
Co.Reg No. 199903512M

☐ Inpatient Claim/Day Surgery Claim ☐ Health Cash Claim ☐ Special Grant Claim (For Smart Care Policy only)

A. Employer (For Group Policy)

Full Name

B. Policyholder's (For Individual Policy)/Employee's (For Group Policy) Particulars

Full Name

NRIC/FIN/Passport No.

Date of Birth (DD/MM/YYYY)

Nationality

Contact Number (Mobile)

Gender ☐ Female ☐ Male

Email

C. Patient's Particulars (If Patient is a dependent of the Policyholder/Employee)

Full Name

Relationship ☐ Spouse ☐ Child

NRIC/FIN/Passport No

Date of Birth (DD/MM/YYYY)

Gender ☐ Female ☐ Male

D. Please complete if Inpatient/Day Surgery was due to Accident (if applicable)

Date of Accident (DD/MM/YYYY)

Time of Accident

Place of Accident

Describe how the accident happened (Please enclose a copy of the police report, if any)

Describe in details the injury(s) sustained, indicating the part of the body injured and the type of injury (eg. fracture, cut, bruise etc.)

Was it work related? ☐ Yes ☐ No

Are you entitled to claim against Work Injury Compensation? ☐ Yes ☐ No

E. Please complete if Inpatient/Day Surgery was due to Illness (if applicable)

Nature of sickness (describe the symptoms suffered)

Date symptoms first started (DD/MM/YYYY)

Date of first consultation with a doctor for this condition (DD/MM/YYYY)

Has the patient ever seen a doctor for any similar conditions in the past? ☐ Yes ☐ No

Name of doctor

Address of doctor/hospital

F. Please provide these additional information if Inpatient/Day Surgery was outside Singapore (if applicable)

Purpose of the overseas trip

Date of departure and return to Singapore/own area of cover (Pls provide proof of travel e.g Flight details/passport copy)

From To

G. Please complete if you are making a Special Grant claim (For Smart Care Policy only)

Date of death (dd/mm/yyyy)

Place of death

(Pls specify name of hospital if death occured in hospital)

Cause of death

H. Other Information

Have you claimed or do you intend to claim from any insurer,other employer or any parties for reimbursement of your medical bills?

☐ Yes ☐ No

If 'yes',please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party?

Note: it is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill(s).You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

Are you claiming for cash benefit for your Inpatient claim? (For International Exclusive Policy) ☐ Yes ☐ No

Note: This benefit is payable provided we do not bear the cost of your Inpatient claim

I. To be completed by employer (Applicable for Smart Care Headcount Policy only)

Company Name

Date of employment (DD/MM/YYYY)

Designation/Grade of Employee

Effective date of coverage (DD/MM/YYYY)

Plan No./Plan Type

Date (DD/MM/YYYY) , Signature of Employer and Company Stamp

J. Payment Details

1. Benefits should be made payable to

☐ Policyholder/Employer ☐ Claimant/Employee ☐ Third Party (For International Exclusive Policy only)

2. Payment is to be made by

☐ Cheque ☐ Direct Credit (For International Exclusive Policy only)

☐ Overseas Telegraphic Transfer (For International Exclusive Policy)

Name of Bank ______ Name of Account Holder ______

Bank Code ______ Branch Code ______ Account Number ______

For overseas telegraphic transfer, please provide these additional information

Bank Address ______

IBAN/SWIFT Code ______

K. DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT

[Declaration] I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

[Authorization] I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.

[Customer's Data Privacy Consent] In connection with my/our and/or the claimant's claims, I/We give consent for AXA Insurance Pte Ltd ("AXA") and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or the claimant, 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 and the Policyholder when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder Group Policy(ies) with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purposes").

Full Name, NRIC/Fin/PP no. & Signature of Claimant/Employee
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY) ______

Full Name, NRIC/Fin/PP no. & Signature of Patient
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY) ______

L. TRACK YOUR CLAIM STATUS

Should you have any query on your claim status,please contact us at the following

www.axa.com.sg (File a Claim)

1800 880 4888

(65)6322 2555

customer.care.health@axa.com.sg (Smart Care Policy)

ops@ipa.sg (International Exclusive Policy)

AXA Insurance is committed to making your claim submission simple and easy.

Thank you for insuring with AXA Insurance, we are proud to serve you.

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Medical Report

Policy No.

To be completed by your treating doctor if you have attended a private hospital or a hospital outside Singapore

1. Name of Patient
2. NRIC/FIN/Passport No.
3. Date admitted (DD/MM/YYYY) Date discharged (DD/MM/YYYY)
4. Was patient referred to you by another doctor? ☐ Yes ☐ No

   If "Yes", please state date of referral and provide us with the name and address of referring doctor.

   Date of Referral (DD/MM/YYYY) Name of Doctor and address of clinic
5. When did patient first consult you for the condition? Date of first consultation (DD/MM/YYYY)
6. What were the complaints or symptoms presented during the first consultation?
7. When did patient first experience these complaints or symptoms? Date of first consultation (DD/MM/YYYY)
   If there were no complaints or symptoms, what prompted the patient to see you?
8. In your expert opinion, per history provided to you by patient and given the etiology of the condition, please state the estimated duration of such condition would be in existence for this patient.
9. Has patient received any prior treatment for these complaints or symptoms? ☐ Yes ☐ No

   If "Yes" please state when and provide us with the name and address of doctor who treated patient previously.
10. Principal Diagnosis

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Other diagnosis(es)

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Note: If there is more than one diagnosis, please advise whether they are related directly to each other. If yes, please provide us with details to your answer.

☐ Yes ☐ No

11. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 10?

12. Did patient suffer or is suffering from any other co-morbidity (ies) that is/are related to diagnosed condition(s)?

☐ Yes ☐ No If 'Yes', please specify

Co-morbidity(ies)	Date of treatment	Name and address of doctor

13. Was surgery performed for the diagnosed condition(s)?

☐ Yes ☐ No If 'Yes', please specify

Date of Surgery	TOSP Code	Table	Description

14. If 2 or more surgeries were performed, please specify whether they were done through same incision.

15. If no surgery was performed, please state treatment and medication given.

If patient was admitted for a maternity condition, please complete this section

16. a) Patient's LMP (DD/MM/YYYY)

b) Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means?

☐ Yes ☐ No If "Yes", please provide details to your answer

c) Type of delivery ☐ Vaginal Delivery ☐ Elective Caesarean Section ☐ Emergency Caesarean Section

If Emergency Caesarean Section, please advise reason(s)

d) Did any complications arise during pregnancy? ☐ Yes ☐ No If 'Yes', please provide details to your answer

If patient was admitted for miscarriage, please complete this section

17. Was it due to an accident? ☐ Yes ☐ No

If yes, please describe how it happened?

If no, please state the cause of the miscarriage?

If patient was admitted due to an accident, please complete this section

18. Was the treatment related to accident? ☐ Yes ☐ No

Date of accident (DD/MM/YYYY)

☐ Road traffic accident ☐ Work related accident ☐ Others If 'Others', please specify

Please describe how it happened?

Was patient's diagnosed condition(s)/ surgery(ies)/ treatment due to or related to any of the following

19.

Condition			Condition		
Dental condition	☐ Yes	☐ No	A psychiatric condition	☐ Yes	☐ No
Abortion	☐ Yes	☐ No	Alcohol Dependence/Substabce Abuse	☐ Yes	☐ No
Infertility/Sub-fertility/ Impotence/ Contraception/ Sterilisation	☐ Yes	☐ No	Sleep Apnoea/Sleep Disorder	☐ Yes	☐ No
			Self-inflicted injury/Attempted Suicide	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No	Refractive error of the eye(s)	☐ Yes	☐ No
AIDS or HIV	☐ Yes	☐ No	Obesity/ Weight Reduction/Weight Improvement	☐ Yes	☐ No
A congenital condition	☐ Yes	☐ No			
Learning disorder/Behavioural problem/Physical & Psychological development problem				☐ Yes	☐ No

20. Was the treatment a/ an

☐ Experimental medical treatment ☐ Cosmetic/ Plastic surgery

If you have ticked any boxes, please give details of the treatment(s)/surgery(ies).

21 Any other information that may assist us in the assessment of the claim.

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s) and the facts as given above represent my opinion of his/ her condition. I declare and agree to make the declaration on this claim form.

Signature of Doctor ____________________

Date ____________________

Name of Doctor ____________________

Hospital/Clinic stamp ____________________