MEDICAL CLAIM FORM

IMPORTANT INFORMATION

Please return this form with original invoices to HOUGHTON STREET CONSULTING PTE LTD. Claims can also be submitted through email but original copies are required for claim payment. Please ensure the name on the invoice is the same as that on your ID/Passport, and that all sections of the claim form are fully completed. The form should be returned to us within six months of the initial treatment date. We are unable to return original documents, but we will be happy to provide certified copies on request.

PATIENT'S DETAILS	
Member #:	Name:
DOB: MM/ DD/ YY/	Gender:
Nationality:	ID/Passport Number:
Tel.:	Email:
Employer (for group member only):	Ref. # (refer to insurance card):
Policy #:	
Address:	

PRINCIPAL MEMBER'S DETAILS (if patient is under 16 years old)	
Name:	DOB: MM/ DD/ YY/
Gender:	ID/Passport Number:
Tel.:	Email:
Address:	

THIRD PARTY INSURERS
Are some of the costs recoverable from someone else (for example: other insurer or a person / organisation involved in an accident?): □Yes □ No Details of the third party (Name, contact information):

PAYMENT DETAILS	
Who would you like us to pay? *(please tick one only)*	
□ Doctor / Hospital	□ Principal Member
□ Patient	□ Group (if on a company plan)
Account Number:	Account Name / Payee:
Bank Name:	Swift Code:
Bank Address:	

DECLARATION
The above answers are true and correct to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to the Service Center including copies of records, concerning advice, care or treatment provided to me or my dependent as is required to properly pay all benefits, if any, due me, or my dependent for this claim. If this claim is direct billed, I acknowledge that I am responsible for any fees that my insurance policy does not cover. A photocopy of this authorization shall be considered as effective and valid as the original.
Patient's Signature (Parent's or Guardian's if Patient is under 16 years old):
Date: MM/ DD/ YY/

EXPLORER

HSC

MEDICAL DETAILS

Please note: A photocopy of the medical record(s), prescription details, expense breakdown or other relevant documents from the outpatient visit(s) may replace this part of the Claim Form. Please submit discharge summary if it is an inpatient claim.

Doctor's Name:	Phone Number:	
Hospital's Name:	Address:	
Diagnosis:		
Onset date when symptoms first noticed by patient	MM/ DD/ YY/	
When did the patient first see a doctor?	MM/ DD/ YY/	
Chief Complaint:		
Physical Examination:		
Lab Tests and Exams:		
Lab tests' Results:		
Exam Results:		
Diagnosis/Impression:		
Details of treatments:		
Details of operation:		
Details of medication (Please state name of drug(s) and dosage(s), otherwise your claim payment will be delayed):		

Treatment is related to (Please check box if related to one of the following items):

☐ Maternity/Pregnancy
☐ Physiotherapy
☐ Acupuncture
☐ Check-up
☐ Immunization
☐ Dental
☐ Vision
☐ Other

Date of Service	**Service Type**	**Charges**
	Consultation	
	Medications	
	Lab Tests	
	Exams	
	Treatments	
	Other	
	Total	

Medical Practitioner's/Surgeon's Signature:

Date: MM/ DD/ YY/

*Please send this completed Claim Form, along with the photocopy of the patient's valid picture ID card / Passport & insurance card, original Invoice(s)/Receipt(s), photocopy of your medical record, prescription (if any) and discharge summary (for inpatient claims), to HOUGHTON STREET CONSULTING PTE LTD.