

## HOW TO FILE A GROUP MEDICAL INSURANCE CLAIM

For **Outpatient Claims**, please assist to submit the following:-

- a) Duly completed Claim Form (Section 1)
- b) All original final hospital tax invoices, doctor's bill and receipts.
- c) Referral Letter from General Practitioner (GP) to Specialist / Hospital
- d) Any referral form for laboratory / blood test
- e) Copy of appointment card to Specialist / Hospital

For **Inpatient Claims**, please assist to submit the following:-

- a) Duly completed Claim Form (Section 1)
- b) All original final hospital, doctor's bill and receipts. For admission / surgery at Private Hospital / clinics, please provide Original Final Summary Hospital Bill and Original Final Itemised Hospital Bill.
- c) Refer to the guidelines\*\* below on the requirement for completion of Section 2 of the Claim Form
- d) Other additional supporting documents (if any) on the medical condition that can assist in the assessment of the claim:
  - Inpatient Discharge Summary
  - Ambulatory Form / Pre Admission Form
  - Referral Letter from General Practitioner (GP) to Specialist / Hospital
  - Any referral form for laboratory / blood test

Note: The Insured Member is required to furnish us the above documents within one month of discharge from the hospital.

### **\*\* GUIDELINES FOR THE REQUIREMENT OF MEDICAL REPORT**

The following procedure applies to claimants who are admitted into the various hospitals:

Hospitalization at	Medical Report to be applied by :	Procedures	Cost of Medical Report to be borne by Aviva Ltd :
Private Hospitals	Claimant	To submit Section 2 of the Claim Form duly completed by the Attending Physician / Surgeon to Aviva Ltd	Nil
*AH, *CDC, *CGH, *KKH, *NCC, *NHC, *NSC, *NUH, *SGH, *SNEC, *TTSH & other Singapore Govt./ Restructured Hospitals	Aviva Ltd	Aviva Ltd will apply for the report, where necessary. The report fee in excess of S\$75 will be recovered from the client once the claim has been processed.	S\$75/-

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| <ul style="list-style-type: none"> <li>* AH – Alexandra Hospital</li> <li>* CDC – Communicable Disease Centre</li> <li>* CGH – Changi General Hospital</li> <li>* KKH – KK Women's and Children's Hospital</li> <li>* NCC – National Cancer Centre</li> <li>* NHC – National Heart Centre</li> </ul> | <ul style="list-style-type: none"> <li>* NSC – National Skin Centre</li> <li>* NUH – National University Hospital</li> <li>* SGH – Singapore General Hospital</li> <li>* SNEC – Singapore National Cancer Centre</li> <li>* TTSH – Tan Tock Seng Hospital</li> </ul> |
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**SECTION 2 (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)**

**For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.**

1) Name of Patient  NRIC / Passport No:	2) Name of Insured Person's company :																																
3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness* or extent of injury.  Date of Diagnosis	DRG Code [ ][ ][ ][ ][ ][ ]																																
4) What is the cause of illness/injury?	ICD Code [ ][ ][ ][ ][ ][ ]																																
5) Is the condition/treatment related to: a) Pregnancy or childbirth b) Abortion or Miscarriage c) Infertility or Sub=fertility Condition d) Congenital Anomaly e) Genetic or Chromosomal Disorder f) Mental or Psychiatric Condition g) Cosmetic Surgery	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:70%;">If "Yes", please elaborate.</td> <td style="width:10%; text-align: center;">No</td> </tr> <tr> <td>a)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>b)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>c)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>d)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>e)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>f)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> <tr> <td>g)</td> <td style="text-align: center;">[ ]</td> <td>_____</td> <td style="text-align: center;">[ ]</td> </tr> </table>		Yes	If "Yes", please elaborate.	No	a)	[ ]	_____	[ ]	b)	[ ]	_____	[ ]	c)	[ ]	_____	[ ]	d)	[ ]	_____	[ ]	e)	[ ]	_____	[ ]	f)	[ ]	_____	[ ]	g)	[ ]	_____	[ ]
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e)	[ ]	_____	[ ]																														
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6) Please specify the approximate date of discovery of the illness or injury	7) How long has the illness / injury been existing prior to consulting you?																																
8) Did the patient have any symptoms prior to consulting you ? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate the nature of Symptoms and date Symptoms first started:																																	
9) When did the patient first consult you for this condition	10) Nature and Date of Treatment rendered.																																
11) Has the patient ever had the same or similar condition / symptom? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge	If "Yes", please indicate when and describe																																
12) Doctors previously consulted by the patient for the above condition. <u>Name of Doctor</u> <u>First Consultation Date</u> <u>Name of Clinic</u> <u>Address</u>																																	
13) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given	14) Date of surgical procedures or treatment rendered : _____ Operation Code [ ][ ][ ][ ][ ][ ] Operation Table [ ][ ]																																
15) If excision was performed, please indicate the size of the lesion / tumor. (Pleas attach a copy of the Histology Report)	16) Name of a) Physician _____ b) Surgeon _____ c) Anaesthetist _____																																
17) Is the surgery done for cosmetic reason? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the surgery for correction of short sightness? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the surgery for dental purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", please explain why surgery is necessary.																																
18) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", please give date service was terminated and furnish name and address of doctor if the patient has been referred to another doctor for follow-up.																																
19) Admission period	20) What is the prognosis of this illness?																																
<p>* Please (✓) the appropriate illness classification.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"><input type="checkbox"/> Alimentary system, includes liver &amp; biliary tract</td> <td style="width:33%;"><input type="checkbox"/> Diseases of the nervous system</td> <td style="width:33%;"><input type="checkbox"/> Metabolic &amp; Endocrine disease</td> </tr> <tr> <td><input type="checkbox"/> Musculo-skeletal system &amp; connective tissue disorder</td> <td><input type="checkbox"/> Cancer / Malignant tumour growth</td> <td><input type="checkbox"/> Eye</td> </tr> <tr> <td><input type="checkbox"/> Haematological disorders / autoimmune disorder</td> <td><input type="checkbox"/> Respiratory system</td> <td><input type="checkbox"/> Female disease / condition</td> </tr> <tr> <td><input type="checkbox"/> Diseases of skin and subcutaneous tissue</td> <td><input type="checkbox"/> Cardiovascular system</td> <td><input type="checkbox"/> Infectious disease</td> </tr> <tr> <td><input type="checkbox"/> Symptoms, signs and ill-defined conditions</td> <td><input type="checkbox"/> Ear, Nose &amp; Throat system</td> <td><input type="checkbox"/> Dental / bucco - mucusal</td> </tr> <tr> <td><input type="checkbox"/> Diseases of genito-urinary system</td> <td><input type="checkbox"/> Psychological / Psychiatric</td> <td></td> </tr> </table>		<input type="checkbox"/> Alimentary system, includes liver & biliary tract	<input type="checkbox"/> Diseases of the nervous system	<input type="checkbox"/> Metabolic & Endocrine disease	<input type="checkbox"/> Musculo-skeletal system & connective tissue disorder	<input type="checkbox"/> Cancer / Malignant tumour growth	<input type="checkbox"/> Eye	<input type="checkbox"/> Haematological disorders / autoimmune disorder	<input type="checkbox"/> Respiratory system	<input type="checkbox"/> Female disease / condition	<input type="checkbox"/> Diseases of skin and subcutaneous tissue	<input type="checkbox"/> Cardiovascular system	<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Symptoms, signs and ill-defined conditions	<input type="checkbox"/> Ear, Nose & Throat system	<input type="checkbox"/> Dental / bucco - mucusal	<input type="checkbox"/> Diseases of genito-urinary system	<input type="checkbox"/> Psychological / Psychiatric															
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