

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, *KTP, *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/-

* AH	-	Alexandra Hospital	* NHC	-	National Heart Centre
* CDC	-	Communicable Disease Centre	* NSC	-	National Skin Centre
* CGH	-	Changi General Hospital	* NUH	-	National University Hospital
* KKH	-	KK Women's and Children's Hospital	* SGH	-	Singapore General Hospital
* KTP	-	Khoo Teck Puat Hospital	* SNEC	-	Singapore National Eye Centre
* NCC	-	National Cancer Centre	* TTSH	-	Tan Tock Seng Hospital

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 ICD Code ICD Code <table style="width:100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>																																
4) What is the cause of illness/injury?																																	
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;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 70%;">If "Yes", please elaborate.</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>a)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>b)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>c)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>d)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>e)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>f)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>g)</td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		Yes	If "Yes", please elaborate.	No	a)	<input type="checkbox"/>	_____	<input type="checkbox"/>	b)	<input type="checkbox"/>	_____	<input type="checkbox"/>	c)	<input type="checkbox"/>	_____	<input type="checkbox"/>	d)	<input type="checkbox"/>	_____	<input type="checkbox"/>	e)	<input type="checkbox"/>	_____	<input type="checkbox"/>	f)	<input type="checkbox"/>	_____	<input type="checkbox"/>	g)	<input type="checkbox"/>	_____	<input type="checkbox"/>
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g)	<input type="checkbox"/>	_____	<input type="checkbox"/>																														
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. <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><u>Name of Doctor</u></td> <td style="width: 20%;"><u>First Consultation Date</u></td> <td style="width: 30%;"><u>Name of Clinic</u></td> <td style="width: 20%;"><u>Address</u></td> </tr> </table>		<u>Name of Doctor</u>	<u>First Consultation Date</u>	<u>Name of Clinic</u>	<u>Address</u>																												
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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 : _____ <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><u>Operation Code</u></td> <td style="width: 40%;"><u>Operation Table</u></td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> </td> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> </td> </tr> </table>	<u>Operation Code</u>	<u>Operation Table</u>	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>							<table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																						
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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 sightedness? <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?																																
* Please (✓) the appropriate illness classification. <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Alimentary system, includes liver & biliary tract <input type="checkbox"/> Musculo-skeletal system & connective tissue disorder <input type="checkbox"/> Haematological disorders / autoimmune disorder <input type="checkbox"/> Diseases of skin and subcutaneous tissue <input type="checkbox"/> Symptoms, signs and ill-defined conditions <input type="checkbox"/> Diseases of genito-urinary system </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Diseases of the nervous system <input type="checkbox"/> Cancer / Malignant tumour growth <input type="checkbox"/> Respiratory system <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Ear, Nose & Throat system <input type="checkbox"/> Psychological / Psychiatric </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Metabolic & Endocrine disease <input type="checkbox"/> Eye <input type="checkbox"/> Female disease / condition <input type="checkbox"/> Infectious disease <input type="checkbox"/> Dental / bucco - mucusal </td> </tr> </table>		<input type="checkbox"/> Alimentary system, includes liver & biliary tract <input type="checkbox"/> Musculo-skeletal system & connective tissue disorder <input type="checkbox"/> Haematological disorders / autoimmune disorder <input type="checkbox"/> Diseases of skin and subcutaneous tissue <input type="checkbox"/> Symptoms, signs and ill-defined conditions <input type="checkbox"/> Diseases of genito-urinary system	<input type="checkbox"/> Diseases of the nervous system <input type="checkbox"/> Cancer / Malignant tumour growth <input type="checkbox"/> Respiratory system <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Ear, Nose & Throat system <input type="checkbox"/> Psychological / Psychiatric	<input type="checkbox"/> Metabolic & Endocrine disease <input type="checkbox"/> Eye <input type="checkbox"/> Female disease / condition <input type="checkbox"/> Infectious disease <input type="checkbox"/> Dental / bucco - mucusal																													
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