Evolution Health Plan (EU)

Claim Form

Checklist

Please tick to indicate that you have provided us with the following:

1. A fully completed Claim Form (including section 7)
2. Bank Details Form
3. All invoices relating to the treatment received
4. Proof of Payment
5. If applicable, the letter of referral and/or Medical Report

Please note, if any of the above are either incomplete or missing, your claim will not be processed and the incomplete or missing information will be requested. We may also require further information in addition to the above. We shall contact you if further information is required.

Important Notes

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

— A **fully completed form** will speed up the assessment and payment of your claim. Any claim form which has not been fully and properly completed cannot be processed and will be returned for completion.

— Please complete **sections 1 - 5** of this document and ask your treating doctor/dentist to complete **sections 6 - 7**. Please note, any fee charged for completing these sections is your responsibility.

— A **separate claim form** is required for every patient and each medical condition.

— For continuation Claims - A new claim form signed and stamped by your treating physician is required each new policy year. We require an update on your health annually with confirmation of the status of the condition and any treatment required.

— Please complete this form in BLOCK CAPITALS, and remember that you **must** submit your claim form together with all supporting invoices and documents **within 3 months of the treatment date otherwise it will not be considered for settlement**.

— Within the detailed benefit schedule, it is shown where certain benefits need pre-authorisation, for example, in-patient/day-patient and medical evacuation/repatriation. If you wish to make a claim on one of these benefits, you need to call us on +44 (0) 3300 581 668 and select Option 3, or send an email to mpclaims@morgan-price.com, with the details of your claim.

IF YOU GO AHEAD WITHOUT OUR APPROVAL A CO-INSURANCE OF 25% OF THE ELIGIBLE COSTS INCURRED WILL APPLY TO YOUR CLAIM.

— Please complete and submit a Bank Details Form with your first claim so that we can make payment to your nominated bank account.

— If you have a query relating to a claim, you can e-mail us at mpclaims@morgan-price.eu or telephone +44 (0) 3300 581 668

By post

Post the original documents to:
Morgan Price (Europe) Claims, ØENS
Virksomhedsadministratio ApS.
Lergravsvej 59, 1
2300 København s,
Denmark

We recommend that you keep copies of all documents that you send to us should you require them at a later date.

By email

If you choose to submit your claim by e-mail to, then please ensure that all documents are clearly scanned. Don't forget to scan both sides of a document if appropriate.

You must retain the original documents as we reserve the right to request these to process your claim.
E-mail: mpclaims@morgan-price.eu

PLEASE ENSURE ALL SECTIONS ARE COMPLETED

1 Claim details

Is this a new claim? Yes No

Is this a continuation of a previous claim with Morgan Price?
If yes, please provide a claim number if you have one. Claim No.

Is this a claim for which you have obtained pre-authorisation? Yes No Pre-authorisation No.

2 Policyholders details

Policy number

Title | Forename(s) | Surname

Correspondence address | Post/Zip code

Phone | Mob | Email

3 Patient details

Title | Forename(s) | Surname

Date of birth

Are the expenses recoverable either in whole or in part from any other source or insurance policy? Yes No

If yes, please give details including name of the other insurer and the policy number:

Are you entitled to benefits under any state care funded medical care scheme? Yes No

If yes, please give details including the state care scheme, your reference number and confirm the level of benefit covered.

4 Claim information

a. Please indicate the type of claim this is: Accident/Injury Illness/Medical condition Wellness/Dental Pregnancy

b. Depending on the type of claim you have ticked, please answer the following questions:

Accident/Injury:

Please confirm the date, time and location of the accident/injury:

Please provide details of the injury and how the injury happened:

Were you under the influence and/or suffering from the effects of alcohol, intoxicants or drugs/narcotics (including any medication), at the time of the accident? If yes, please specify which including names of medications:

Have you ever injured this part of the body before? If yes, please provide the date:

Were there any other parties involved in the accident or who may have contributed to the accident? If yes, please provide details, including if they have any relating insurance:

Are you or will you be seeking legal proceedings?

4 Claim information — continued

Illness/Medical condition:

Please provide details of the symptoms you were experiencing and the name of the condition:

Please confirm the date you first suffered symptoms:

Have you ever suffered with these symptoms or any related condition previously? If yes, please provide the dates and details of any previous treatment, including any over the counter medication:

Wellness/Dental:

If your claim is relating to treatment for the replacement of existing crowns, inlays, fillings, bridges or missing teeth, please provide details of your symptoms, the date you first became aware of the symptoms and details of any previous treatment:

If your claim is for a vaccination, please confirm the reason you required the vaccine:

Pregnancy:

Please confirm your expected due date:

Please confirm if any form of assisted reproduction has been used? If so, please provide details:

c. Please list below the invoices you are submitting for reimbursement (Please note, if any of the invoices you submit are unclear, these will be sent back to you):

Date of treatment	Expenses for which reimbursement is required	State the currency and amount paid	To whom should we make settlement*	Currency of reimbursement

*** Please ensure that a Bank Details Form has been provided to us.**

5 Patient signature and release

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Morgan Price Europe, or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient signature | Date

6 Dental claims (to be completed by treating dentist)

Name of dentist | Qualifications/credentials

Dental clinic name | Phone | Email

Address

Post/Zip code | Country

Patient's full name | Patient's date of birth

Please confirm the date the patient first registered at your facility/How long have you known the patient?

Has the patient been attending regular routine check-ups? Yes No

Date that the patient visited you for treatment:

Reason for the visit:

Was the patient suffering dental pain at the time he/she visited you for treatment? Yes No

Is the treatment for the replacement of existing crowns, inlays, fillings, bridges or missing teeth? Yes No
If yes, please provide details including the date of onset and previous treatment:

Is the treatment for gingivitis, periodontosis, or gum disease of any kind? Yes No

Date of the patient's last check-up:

Reason for check-up:

Dentist signature | **Date**

This section must either be typed or completed in BLOCK CAPITALS.

7 Medical information (to be completed by treating physician)

Name of doctor/specialist | Qualifications/credentials

License Number | Governing Body

Hospital/clinic name | Phone | Email

Address

Post/Zip code | Country

Patient's full name | Patient's date of birth

Please confirm the date the patient first registered at your facility/How long have you known the patient?

Indicate type of treatment received | Elective | Emergency | Routine wellness check-up

ICD code:

Please provide full details, including symptoms, of the medical condition requiring treatment and the treatment given. Please include any relevant diagnostics and the results:

Was this their first visit to you? If yes, were they referred to you? If yes, please provide details of the person referring them.

On what date did the patient first present these symptoms to you?

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition?

Are you aware of any treatment given for this or any related illness in the past? | Yes | No

7 Medical information (to be completed by treating physician) — continued

For out-patient psychiatric treatment, please provide the following details:

Name of referring physician

Phone | Date of referral

Doctors signature | **Date**

Doctors/Dentist stamp

The confidentiality of patient and member information is of paramount concern to us. Morgan Price (Europe) ApS, their insurers and appointed representatives, fully comply with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.