PJICO
PETROLIMEX INSURANCE CORPORATION

MEDICAL CLAIM FORM

(This claim form is not an admission of liability)

Prior approval no.:

Membership card number:

Date received:

Received by:

Please complete this form in full in order to assure a fast and accurate processing.
All fields are compulsory. We will not be able to process for incomplete form.

A. ADMINISTRATIVE *(Section A to be completed by policyholder)t*

Policyholder:	**Policy number:**
E-mail:	**Contact number:**

PATIENT/INSURED PERSON'S DETAILS

Patient/insured person'sname:		**Date of birth:** *(dd/mm/yyyy)*
ID/Passport number:	**Gender:** Male ☐ Female ☐	**Plan:**
E-mail:		**Contact number:**

FOR GROUP POLICYHOLDERS ONLY

Name of employer:	**Insured person's occupation:**
Date joined employer: *(dd/mm/yyyy)*	**Name of authorized officer:**

B. MEDICAL DETAILS

Was there any previous consultation / treatment / hospitalization for this condition and/or associated conditions or symptoms, in this hospital or any other facilities (for example but not limited to clinic, TCM, alternative practitioner etc)? Yes ☐ No ☐
If Yes, please provide details below:

Date *(dd/mm/yyyy)*	**Disease / disorder** *(details of treatment/consultation)*	**Name of doctor & hospital/ facility**	**Contact address & telephone details**

Please provide details of your or patient's regular doctor(s)/company doctors(s)/other doctors below if any.

Date *(dd/mm/yyyy)*	**Disease / disorder** *(details of treatment/consultation)*	**Name of doctor & hospital / facility**	**Contact address & telephone details**

If the medical condition/injury was caused by an accident, please describe how the accident occurred and provide copy of the accident report from the recognized Authority/Medical body.

C. MEDICAL SECTION *(Section B to be completed by medical practitioner)*

Symptoms presented:	**Date the patient first became aware of any signs or symptoms for this condition:** *(dd/mm/yyyy)*	**Date on which the patient first presented to any doctor for this condition:** *(dd/mm/yyyy)*

Medical condition / diagnosis:

Investigation (describe necessary investigations requested / required to define the diagnosis):

Further treatment plan:

If claim is related to pregnancy, is pregnancy conceived from natural conception? Yes ☐ No ☐

Date of admission & discharge *(applicable to hospitalization only)*: to
(dd/mm/yyyy)

In your opinion given the etiology of the condition how long do you think the condition has been presented?

Does the patient have any related medical condition? Yes ☐ No ☐ If "Yes", please state and explain the relation

Does the patient has any other significant medical condition? Yes ☐ No ☐ If "Yes", please state the medical condition(s) and the date of diagnosis.

TREATMENT ADVISED *(applicable for pre-authorization only)*

Admitting hospital:	**Date of treatment:**
Treatment plan:	**Estimated length of treatment (in days):**
Room type: **Room charge per night:** **Total estimated room & all hospital charges:**	Estimated cost for treating doctor (i+ii): i. Daily visit estimate cost: ii. Surgery estimate cost: Estimated cost for anaesthetist: Total estimated cost for treating doctor / surgeon & anaesthetist:

MEDICAL PRACTITIONER'S DECLARATION

I declare that I am the patient's medical practitioner, and that the particulars given are true and correct to the best of my knowledge

Name: _____ **Signature:** _____ **Contact number:** _____

Hospital/clinic stamp: Date: .....

D. DECLARATION ANDAUTHORIZATIONBY THE POLICYHOLDER

I hereby declare and authorize:

1. that I authorize the medical practitioner, Hospital / Clinic or any other medical institution to give the information and/or medical record, according to the diagnosis and/or medication treatment which is/has been given to me or my family member who being as the insured,

2. that I authorize PJICO and its designated third party administrators; to gather further information / medical records from the Hospital and or other parties related to the diagnosis and or health services provided to me or my family member which may be required to process the claim in accordance with existing policy and term conditions.

3. that all information on this hospital admission / pre-authorizationclaim form (in-patient) is written truthfully and I hereby agree that this Letter of Authority to be used promptly.

4. that copy of this Declaration is as valid and has power in accordance with the original document.

5. that the approval (where applicable) of this claim does not discharge my obligations to fulfill the terms and conditions under the policy which I and/or family member is/are insured, and also, PJICO is not obliged to pay the ongoing costs of continuing, or similar, treatment, even where PJICO has previously paid for this type of, or similar treatment, if it is subsequently noted that this claim is not an eligible treatment.

6. I authorize my Financial Advisor / Broker / Agent to discuss medical conditions as necessary with my insurer or its authorized agent on my behalf or advise otherwise.

Please tick the box ☐ if you do not authorize your Financial Advisor/Broker/Agent to discuss medical conditions with the insurer or its authorized agent on your behalf.

Policyholder signature: **Date:**

Name of Insured/Policyholder:	**ID/PP no. of Insured/Policyholder:**	**Relationship:**
Signature of Insured/Policyholder:	**Mailing address:**	**Contact no.:**
Name of Financial Advisor/Agent:		**Contact no.:**

E. THE FOLLOWING DOCUMENTS MUST ACCOMPANY THE CLAIM DURING SUBMISSION:

- ☐ Original fully completed Medical Claim Form
- ☐ Original final itemized medical bills and payment receipt (if claiming for cash benefit, certified copy of final medical is acceptable)
- ☐ Copy of diagnostic test result (Laboratory result, X-Ray, etc), discharge summary report
- ☐ Copy of doctor's prescription
- ☐ Certified Copy of final itemized medical bills, payment receipt & Copy of Settlement letter from Insurer/Employer (if claiming balances from PJICO)

F. REIMBURSEMENT OF CLAIMS

Amount claimed:

Telegraphic bank transfer. The account holder must be the policy holder.

Name of beneficiary: ..... **Bank SWIFT code:** .....

Bank account number: ..... **Bank branch:** .....

Name of bank: ..... **Bank address:** .....

If you have any questions regarding this form or any other aspects of the coverage, please contact our Customer Service Team quoting your membership card no. Claims must be submitted along with all supporting documents within 90 days from date of service. Send this claim form together with all supporting documents to Direct Billing and Claim Support team at South Asia Services Liability Ltd. Co - 8th Floor, 208 Nguyen Trai, Dist 1, Ho Chi Minh City - Tel: (+848) 39256780.