Medical Claim Form

FIGTREE BLUE

Please ensure your claim form is fully completed and returned as soon as possible.
Please note that Figtree Blue is not responsible for any fee incurred in the completion of this form or any further information/documents required by us to assess a claim. The issuing of this claim form is in no way an admission of liability.

Policyholder		Policy Number	

For all out-patient claims under US$150 per condition, please complete Section A, B and C and return the original receipt showing the written diagnosis from the doctor and a breakdown of costs. However, all sections must be completed IN FULL for hospitalization claims and all claims over US$ 150. A referral letter from your Specialist should be attached when you are claiming for diagnostic tests or covered alternative Treatments.

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED

Section A – Personal Information

Surname		Address	
First name and initials			
Date of birth		Email	
Home phone		Fax/Mobile	

Do you hold any other insurance under which you could claim? Is yes, please provide details on a separate sheet. ☐ Yes ☐ No

Section B – Claims Settlement

Original currency	
Amount for medication	
Amount for consultation	
Amount for hospitalization	
Amount for others	
Total amount claimed	

How do you wish settlement to be made?
☐ Cheque to home address ☐ Cheque to bank
☐ Bank transfer (not available in some countries)
Bank details (name, address, account number, bank code)

Section C – Declaration

"I declare that all information, to the best of my knowledge, provided on this claim form is truthful and correct. I also understand that this declaration gives permission to FIGTREE Blue and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous **Medical Practitioners**."

"I declare and agree that the personal information collected or held by FIGTREE BLUE, whether contained in this form or obtained otherwise, may be used by FIGTREE Blue or disclosed or transferred to any organization within or outside Cambodia for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment, (3) provide marketing materials in respect of insurance related services of FIGTREE Blue or its associated companies and (4) process claims or analyze the insurance."

Patient's Signature (if patient is under 18 years, parent or guardian must sign) Date:

Section D – Claims Information - to be wholly completed by the Medical Practitioner or Dentist as applicable

Condition requiring treatment

Underlying cause(s)

How long has condition existed?

When were symptoms first apparent to the patient?

Address of referring doctor

Please detail pathology performed and attach the results

Date of first consultation with any Practitioner for this condition

Will the patient require treatment outside the country of residence?
If so, please advise:

Has the condition been suffered from previously?

Please provide dates of previous consultations/treatment

Please confirm the likely period of treatment

Please detail the medication/treatment prescribed or that will be prescribed

Was the treatment in respect of an acute exacerbation of a chronic condition?

Is this a routine checkup? ☐ Yes ☐ No

Declaration – to be completed by the Medical Practitioner/Dentist

Name			
Tel		Fax	
E-mail			
Address			
Signature		Date	

Official Stamp

** IMPORTANT ** - Please ensure that:

1- All original invoices and prescriptions are attached
2- The claim form is completed in full
3- The declarations are signed and dated
4- All laboratory tests are attached
5- The diagnosis and underlying cause have been confirmed.

This will ensure that your claim is reviewed in a timely fashion.

Please return this form to: Figtree Blue Claims Department, 325 Mao Tse Toung Blvd, Phnom Penh, Cambodia
Tel: (855) 23 885 066/077 Fax: (855) 23 986 922 Mobile: (855) 12 777 135 (24hrs) Email: claims@forteinsurance.com