HEALTH CLAIM FORM

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life (Fiji) Limited, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. POLICY HOLDER'S DETAILS

	Given Name(s)	Surname	Policy Number
Mr/Mrs/Miss/Ms			

2. CLAIMANT'S DETAILS (If different from the policyholder)

	Given Name(s)	Surname	Relationship to Policyholder
Mr/Mrs/Miss/Ms			

3. ADDRESS FOR POSTAL CORRESPONDENCE

4. CONTACT DETAILS

Teleohone Home Work Mobile Facsimile

Email

5. ENTITLEMENTS

Do you have any entitlemants to worker's compensation or third party insurance in respect of any terms of this claim or other damages?

No Yes ▶ Please indicate under which entitlemant

6. PATIENT/SERVICE INFORMATION

Please complete the Section that is applicable to your claim. As some conditions require prior approval from BSP Health Care, you are required to complete Section 6(c) below. If you are making a claim in Section 6(a) or 6(c), your medical provider will be required to complete the Medical Provider's Statement which is included in this form and send it to BSP Health Care, Claims Department, Private Mail Bag, Suva. Benefit payments for dependants aged 18-24 are only payable if they are full time students attending an accredited educational institution.

6(a) Hospitalisation/Cash Allowance Claims

Date Patient Hospitalized	Date Patient Discharged	Treatment Received and Condition being Treated or Consulted for	Date of Illness (1st symptom) or Injury (accident) or Maternity Services	Date First Consulted Doctor/Services Provider	Name & Contact of Doctor/Service Provider	Account Paid	Fee Charged
E.g 30/06/2010	*15/07/2010*	*Angina*	*01/02/2010*	*01/06/2010*	*Lautoka Hospital*	*Yes/No*	*S2000*

6(b) HealthPac/Day Care/Outpatient Claims

Type of Service	Treatment Received and Condition being Treated	Name of Doctor/Service Provider	Account Paid	Fee Charged
E.g Dental Optical Allied Services or Others	*Consultation for glasses*	*Praneel Asgar*	*Yes/No*	*$ 15.00*

6(c) Prior Approval (Local Public Hospital, Local Private Hospital, Overseas Hospital)

Please tick the appropriate box	Diagnosis *(enclose medical report/ history)*	Date of Illness *(1st symtom)* or Injury *(Accident)* or Maternity Services	Name of Referring Doctor	Date First Consulted Referring Doctor	Treatment Required
Example	*Tonsillitis*	*10/05/2005*	*Dip Chand*	*12/12/2005*	*Surgery to remove tonsils*
☐ Local Public Hospital ☐ Local Private Hospital ☐ Overseas Hospital					

(If prior approval is granted, the confirmation is subjected to ALL policy conditions being met of the time treatment is provided)

7. PAYMENT DETAILS *(Payment will only be made if premium payments are in order)*

By Cheque

Mail to my postal address Collect by me Collect by Authorized Person (If authority has been received)

Note: ** Cheque may be collected by the policyholder or the authorized person as nominated. All cheques will be posted to the policyholder's postal address.*

** Original itemised receipts must be attached with your Health Claim form. Copies will not be accepted and may delay payment.*

8. AGENT'S AUTHORITY

If you want another person, including your authorized BSP Life sales agent to make the claim on your behalf, please complete the authority below. Both you and your sales agent must sign prior to lodging the claim. Your sales agent will be asked to provide personal identification.

Sales Agent's Signature	**Claimant's Signature**
Sales Agent's Name	**Date**

9. DECLARATION *(to be signed by the claimant)*

I declare that this claim is for the services received by myself and/or my nominated dependant(s), or where prior approval is being sought, is for services referred by a registered medical practitioner for myself and or/my nominated dependant(s).

I declare that to the best of my knowledge, the information is true and correct.

I authorise BSP Health Care to contact the provider of any service claimed for the clarification of any details relating to this claim.

Signature of Claimant	**Date**	**Office Use Only**

BSP Health Care Hotline 321 4444

HOW TO MAKE A CLAIM

Claims for Treatment or medication must be rendered/dispensed exclusively for the eligible person nominated on the policy.

** Complete the claim form.*
** Attach original accounts or receipt, medical, police and other reports relevant to the claim. (Do not attach photocopies).*
** Sign the claim form.*
** Take the claim to BSP Life Health Claims Department or mail your completed Health Claim form to:*

Health Claims Department
BSP Life
Level 5 Dominion House, Thomson Street
Private Mail Bag, Suva, Fiji.

** To ensure prompt receipt of your claim payment, please advise of any changes to your address.*

What you need to attach to your claim

** Itemised accounts and receipts from the doctor/service provider for Hospitalisation/Cash Allowance claims.*
** Itemised accounts and receipts from the doctor/service provider for HealthPac/Day Care/Outpatient claims.*
** Medical report and Prior Approval letter for the prior approval claims.*

Please Note

All documents attached to the claim **must** be originals **and** will be kept by BSP Health Care.

- *When lodging a claim through the post do not send your membership card. Please present the membership card when lodging a claim in person.*
- *Benefits are not payable if your premium payments are not up to date.*
- *BSP Health Care brochures provide a summary of the main benefits and conditions of your medical policy.*

Privacy - Use and Disclosure of the Personal Information.

The privacy of your personal information is important to you. BSP Life will only collect information about you and any others named on your policy that is necessary for the purpose of providing products and services. The information collected may include health information. If the information you give us is incomplete or inaccurate we may not be able to pay your claim.

BSP Health Care may need to disclose your personal information to other parties, such as health care providers and government authorities.

MEDICAL PROVIDER'S STATEMENT

(To be completed for Hospitalisation/Cash Allowance & Prior Approval Claim and on request by BSP Health Care)

Please ask your Doctor/Service Provider to complete this statement.
BSP Life is **NOT** liable for any changes levied by your Physician for this statement.

1. Patient's Name
2. Patient's Date of Birth / /
3. Date of Illness (first symptom) or injury
4. How long have you known the patient?
5. Date patient consulted you for this condition First Consulted / / Last Consulted / /
6. List all the dates on which the patient has consulted you for this condition.

Date	Treatment Received	Date	Treatment Received

7. Objective Findings (Give details of X-Ray, ECGs or other tests)
8. Is this condition a recurrence? No Yes
9. If patient has had similar illness or injury, give dates and details.

Date	Injury or Illness	Details

10. Are there any other conditions affecting recovery from the current condition? No Yes ▶ *If yes, please advise nature or conditions and how they affect recovery?*
11. Was this illness or injury an emergency? No Yes
12. Date patient able to return to work
13. Date of Total Disability
    From: **To:**
14. Date of Partial Disability
    From: **To:**
15. Name of referred Physician
16. Hospitalisation Dates **From:** **To:**
17. Name and Address of facility where treatment services rendered

18. Diagnosis or Nature of illness or injury (Please indicate primary and secondary)

19. Procedures, medical services & suppliers provided

Date of Services	Place of Service	Description of Service	Charges	Number of Days	Diagnosis Code	Office Use Only
/ /			$			
/ /			$			
/ /			$			
/ /			$			
/ /			$			

20. Medical Provider's Name

Postal Address:

Telephone: Facsimile: Email:

Medical Provider's Signature:

Date: Registration No.: Stamp:

Instruction to Health Care Provider

Please send the "Medical Providers Statement" in an envelope marked "CONFIDENTIAL" and addressed to:

The Claims Manager
BSP Life (Fiji) Limited
Private Mail Bag
Suva, Fiji.

Call Centre: 132 700 | 24-hour Health Care Help Desk (679) 326 1787 | Fax: (679) 3308340 | Mobile: (679) 999 4853