HEALTH CLAIM FORM

Local Hospitalisation/Overseas Evacuation

Please submit completed form and supporting documents to: cmbenefitmanagement@bsplife.com.fj
BSP Health Care (Fiji) Limited, Ground Floor, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: (679) 331 7000 Call Centre, 24-hour Health Care help Desk (679): 326 1787 Website: www.bsplife.com.fj

PLEASE READ THESE NOTES:

- Please complete this form in full. Your medical provider must complete and submit the Medical Provider's Statement to BSP Health Care (Fiji) Limited.
- Please provide detailed Medical Report and an estimation of costs for claims.

SECTION A: POLICY DETAILS

Policy Number:

SECTION B: POLICY OWNER DETAILS *(same details on the medical card)*

1. Personal Details:

Title:	First Name:	Middle Name:
Last Name:		Date of Birth:

2. Bank Details:

For efficiency, BSP Health Care (Fiji) Limited makes payments by Electronic Funds Transfer directly into your nominated bank account. Please advise BSP Health Care (Fiji) Limited for any changes to your nominated bank account details.

Bank Name:	Bank Account Number:
Bank Account Name:	

SECTION C: CLAIMANT DETAILS *(same details on the medical card)*

1. Personal Details:

Title:	First Name:	Middle Name:
Last Name:		Date of Birth:
National Health Card Number (Ministry of Health and Medical Services):		

2. Contact Details:

Work No:	Home No:	Mobile No:
Email Address:		Alternate Email Address:

3. Additional Details:

Please provide details of any other Health Insurance Cover held locally or abroad including national health cover as an eligible citizen of another country.

SECTION D: ENTITLEMENTS

Do you have any entitlement to damages, third party insurance or accident compensation in respect of this claim?

☐ Yes ☐ No *If Yes, please indicate under which entitlement:*

SECTION E: PATIENT / SERVICE INFORMATION

1. Hospitalisation Claims

Date Admitted	Date Discharged	Details of Admission	Name & Contact of Doctor / Service Provider	Amount Paid

2. Prior Approval *(Local Public Hospital, Local Private Hospital, Overseas Hospital)*

Please tick the appropriate box	Diagnosis	Name of Referring Doctor	Date First Consulted Doctor/ Service Provider	Treatment Required
☐ Local Public Hospital ☐ Local Private Hospital ☐ Overseas Hospital				

SECTION F: DECLARATION - IMPORTANT, PLEASE READ CAREFULLY	
I **declare** that this claim is for services received by me and/ or my nominated dependent(s), or where prior approval is being sought, is for services referred by a registered medical practitioner for myself and or/my nominated dependent(s). I d**eclare** that the information provided in this form is true and complete. I **authorise** BSP Health Care (Fiji) Limited to obtain all necessary medical and other information from any service provider to process this claim. I **agree** to reimburse BSP Health Care (Fiji) Limited in full if the claim is paid incorrectly and indemnify BSP Health Care (Fiji) Limited for payments made incorrectly to a third party authorised by me.	
Signature of Claimant:	Date:

IMPORTANT INFORMATION		
What you need to attach to your claim: • Itemised accounts and receipts from the doctor/service provider for Hospitalisation/Cash Allowance claims. • Medical Report and Prior Approval letter for prior approval claims.	**Please note:** • All documents attached to the claim will be kept by BSP Health. • When lodging a claim through the post do not send your medical card. Please present the medical card when lodging a claim in person. • Benefits are not payable if your premium payments are not up to date. • BSP Health 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 us. BSP Health Care (Fiji) Limited 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 (Fiji) Limited may need to disclose your personal information to, or obtain from, other parties, such as health care providers and government authorities.

MEDICAL PROVIDER STATEMENT

PLEASE READ THESE NOTES:
- To be completed by the Doctor/Specialist for Local Hospitalisation/Overseas Evacuation claim.
- BSP Health Care (Fiji) Limited is NOT liable for any charges levied by your Doctor/Specialist for providing this statement.

SECTION A: PATIENT'S DETAILS	
Patient Name:	Patient's Date of Birth:

SECTION B: ILLNESS OR INJURY		
Date of Illness (first symptom) or injury:	How long have you known the patient:	
Date patient consulted you for this condition	First Consulted:	Last Consulted:
Is this condition a recurrence? ☐ Yes ☐ No		
Has the patient required surgery, treatment, investigations for this or a similar condition? ☐ Yes ☐ No *If yes please provide details.*		

Date	Injury or Illness	Details

SECTION C: FINDINGS
Objective Findings *(Give details of X-Ray, ECGs or other tests)*

SECTION D: EXISTING MEDICAL CONDITION DETAILS
Are there any other existing medical conditions? ☐ Yes ☐ No *If yes, please advise nature or conditions*
Procedures and medical services provided?

Date of Services	Referring Specialist / Hospital	Details of Medical Services

SECTION E: MEDICAL PROVIDER'S DETAILS	
Medical Provider's Name:	Clinic Name:
Medical Provider's Signature:	
Postal Address:	
Telephone:	Email Address:

RESET FORM