

CLAIMS (EMPLOYEE BENEFITS & HEALTHCARE) DEPARTMENT

HOW TO FILE A GROUP MEDICAL INSURANCE CLAIM

The Insured Member is required to furnish the following documents within one month of discharge from the hospital:

- a) Duly completed Claim Form (Section 1)
- b) All original final hospital, doctor's bill and receipts. For admission/surgery at Private Hospital/clinics, please provide Original Final Summary Hospital Bill and Original Final Itemised Hospital Bill.
- c) Refer to the guidelines** below on the requirement for completion of Section 2 of the Claim Form
- d) Other additional supporting documents (if any) on the medical condition that can assist in the assessment of the claim:
 - Inpatient Discharge Summary
 - Ambulatory Form / Pre Admission Form
 - Referral Letter from General Practitioner (GP) to Specialist / Hospital
 - Any referral form for laboratory / blood test

**** GUIDELINES FOR THE REQUIREMENT OF MEDICAL REPORT**

The following procedure applies to claimants who are admitted into the various hospitals:

Hospitalization at	Medical Report to be applied by :	Procedures	Cost of Medical Report to be borne by Aviva:
Private Hospitals/ Hospitals outside Singapore	Claimant	To submit Section 2 of the Claim Form duly completed by the Attending Physician / Surgeon to Aviva Ltd.	Nil
*AH *SGH, *TTSH, *SNEC, *NUH, *NHC, *NCC, *KKH, *CGH, *NSC, *CDC & other Singapore Govt./Restructured Hospitals	Aviva Ltd	Aviva Ltd will apply for the report, where necessary. The report fee in excess of S\$75 will be recovered from the client once the claim has been processed.	S\$75/-

- * AH - Alexandra Hospital
- * CDC - Communicable Disease Centre
- * CGH - Changi General Hospital
- * KKH - KK Women's and Children's Hospital
- * NCC - National Cancer Centre
- * NHC - National Heart Centre
- * NSC - National Skin Centre
- * NUH - National University Hospital
- * SGH - Singapore General Hospital
- * SNEC - Singapore National Eye Centre
- * TTSH - Tan Tock Seng Hospital

SECTION 2 (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)

* For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

1) Name of Patient: NRIC/Passport no:	2) Name of Insured Person's company:																								
3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness* or extent of injury.	<table style="width:100%; border: none;"> <tr> <td style="text-align: center; border: none;">DRG Code</td> <td style="text-align: center; border: none;">ICD Code</td> <td style="text-align: center; border: none;">ICD Code</td> </tr> <tr> <td style="text-align: center; border: none;"> <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table> </td> <td style="text-align: center; border: none;"> <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table> </td> <td style="text-align: center; border: none;"> <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table> </td> </tr> </table>	DRG Code	ICD Code	ICD Code	<table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table>		<table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table>		<table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td></tr> </table>																
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4) What is the cause of the illness/injury?																									
5) Is the condition/ treatment related to:	<table style="width:100%; border: none;"> <tr> <td style="text-align: center; border: none;">Yes</td> <td style="text-align: center; border: none;">If yes, please elaborate.</td> <td style="text-align: center; border: none;">No</td> </tr> <tr> <td style="border: none;">a) <input type="checkbox"/></td> <td style="border: none;">a) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">b) <input type="checkbox"/></td> <td style="border: none;">b) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">c) <input type="checkbox"/></td> <td style="border: none;">c) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">d) <input type="checkbox"/></td> <td style="border: none;">d) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">e) <input type="checkbox"/></td> <td style="border: none;">e) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">f) <input type="checkbox"/></td> <td style="border: none;">f) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">g) <input type="checkbox"/></td> <td style="border: none;">g) _____</td> <td style="border: none;"><input type="checkbox"/></td> </tr> </table>	Yes	If yes, please elaborate.	No	a) <input type="checkbox"/>	a) _____	<input type="checkbox"/>	b) <input type="checkbox"/>	b) _____	<input type="checkbox"/>	c) <input type="checkbox"/>	c) _____	<input type="checkbox"/>	d) <input type="checkbox"/>	d) _____	<input type="checkbox"/>	e) <input type="checkbox"/>	e) _____	<input type="checkbox"/>	f) <input type="checkbox"/>	f) _____	<input type="checkbox"/>	g) <input type="checkbox"/>	g) _____	<input type="checkbox"/>
Yes	If yes, please elaborate.	No																							
a) <input type="checkbox"/>	a) _____	<input type="checkbox"/>																							
b) <input type="checkbox"/>	b) _____	<input type="checkbox"/>																							
c) <input type="checkbox"/>	c) _____	<input type="checkbox"/>																							
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e) <input type="checkbox"/>	e) _____	<input type="checkbox"/>																							
f) <input type="checkbox"/>	f) _____	<input type="checkbox"/>																							
g) <input type="checkbox"/>	g) _____	<input type="checkbox"/>																							
6) Please specify the approximate date of discovery of the illness or injury.	7) How long has the illness/injury been existing prior to consulting you?																								
8) Did the patient have any symptoms prior to consulting you? Yes <input type="checkbox"/> If yes, please indicate the nature of Symptoms and date Symptoms first started: _____ No <input type="checkbox"/>																									
9) When did the patient first consult you for this condition?	10) Nature and Date of Treatment rendered.																								
11) Has the patient ever had the same or similar condition/symptom? Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge <input type="checkbox"/>	12) If yes, please indicate when and describe.																								
13) Doctors previously consulted by the patient for the above condition.																									
Name	Approximate Date																								
Name of Clinic	Address																								
14) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment/medication given.																									
15) Date surgical procedures or treatment rendered : _____																									
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16) If excision was performed, please indicate the size of the lesion/tumor. (Please attach a copy of the Histology Report)	17) Name of																								
	a) Physician _____																								
	b) Surgeon _____																								
	c) Anaesthetist _____																								
18) Is the surgery done for cosmetic reasons?	19) If no, please explain why surgery is necessary.																								
20) Is the patient still under your care for this condition?	21) If no, please give date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up.																								
22) Admission period	23) What is the prognosis of this illness?																								
*Please tick the appropriate illness classification.																									
<input type="checkbox"/> Alimentary system, includes liver & biliary tract	<input type="checkbox"/> Diseases of the nervous system																								
<input type="checkbox"/> Musculo-skeletal system & connective tissue disorder	<input type="checkbox"/> Cancer/malignant tumour growth																								
<input type="checkbox"/> Haematological disorders/autoimmune disorders	<input type="checkbox"/> Respiratory System																								
<input type="checkbox"/> Diseases of skin and subcutaneous tissue	<input type="checkbox"/> Cardiovascular system																								
<input type="checkbox"/> Symptoms, signs and ill-defined conditions	<input type="checkbox"/> Ear, nose & throat system																								
<input type="checkbox"/> Diseases of genito-urinary system	<input type="checkbox"/> Psychological/Psychiatric																								
<input type="checkbox"/> Metabolic & endocrine disease	<input type="checkbox"/> Eye																								
	<input type="checkbox"/> Female diseases/condition																								
	<input type="checkbox"/> Infectious diseases																								
	<input type="checkbox"/> Dental/bucco-mucosal																								
_____ Signature of Physician/Surgeon	_____ Date (DD/MM/YY)																								
_____ Name/Designation	_____ Name and Address of Clinic/Hospital																								