LIBERTY

Invoice Number

Health Cover Claim Form

Important: Please read the following before completing this form.

This form must be completed for every patient receiving treatment. Please complete a separate claim form for each visit and attach the related and detailed invoice to ensure quick processing and payment. The patient should be given a copy of this form for their records. Please write clearly in CAPITAL LETTERS.

Please note: The Insurer will reject unclear or incomplete claims.

PATIENT DETAILS

First name | Last name

Member No. | Dep Code | Gender (M/F) | Date of Birth (DD/MM/CCYY)

PRINCIPAL MEMBER DETAILS

First name | Last name

Employer | Email

Contact (please include country and area code)

SERVICE PROVIDER DETAILS

Name of facility | Consulting physician

Provider no. | Speciality

Treatment date (DD/MM/CCYY)

If hospitalisation was required, please indicate the duration of stay | Admission date (DD/MM/CCYY) | Discharge date (DD/MM/CCYY)

CLAIM INFORMATION

Description of diagnosis

Is this claim maternity related? Y N

Description of treatment (e.g. consultation, medication, tests. etc.)	Code	Qty	Dosage	Cost
	Total Medical Costs (include Currency)			

PROVIDER'S DECLARATION

I certify that the above patient received the services and treatment noted on this form, that the diagnosis was made by me, and that the information provided on this claim is true and in accordance with the related treatment specified by me.

Signed | Date (DD/MM/CCYY)

PATIENT'S DECLARATION

I hereby declare the above stated to be true and in accordance with the rules and available benefits of Liberty Health Cover (Liberty Blue). I confirm that the amount claimed herein is not claimable from another source and that as a member or dependant of Liberty Health Cover (Liberty Blue), I received the above services and treatment. I authorise the service provider to disclose the nature of illness to the Insurer for their confidential use and I agree that no awards will be made for this treatment unless contributions were received for the period of treatment. Should claims be paid for the principal member or his or her dependants following termination of cover, the Insurer reserves the right to recover the related costs incurred from the principal member.

Signed | Date (DD/MM/CCYY)

PROVIDER STAMP