

**CLAIM FORM – [For use on Brit Insurance Limited underwritten policies]**

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim;
- Please complete the front page of this form and ask your treating doctor to complete the back page;
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted;
- If you are submitting invoices from Germany or the USA, or if your invoices contain details of diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form, simply attach the original invoices;
- A separate claim form is required for every patient and each medical condition;
- We recommend that you keep copies of all documents submitted, should you require them at a later date;
- Finally we kindly ask that you complete this form in **BLOCK CAPITALS**, and post to the address below, within 3 months of the treatment date.

**IMPORTANT:** IF THIS CLAIM IS A CONTINUATION OF A PREVIOUS CLAIM WITH MORGAN PRICE, OR FOR A CONDITION WHICH YOU HAVE CLAIMED FOR BEFORE, PLEASE TICK HERE [  ] AND PROVIDE DETAILS ON A COVERING SHEET.

**1. Policyholders Details**

<b>Policy Number (Must be completed)</b>			<b>Title</b>	
<b>Surname</b>		<b>First Name(s)</b>		
<b>Correspondence address</b>				
		<b>Postcode</b>		
<b>Phone No. (Daytime)</b>		<b>(Evening)</b>		
<b>Mobile Phone No.</b>		<b>Fax</b>		
<b>Email</b>				

**2. Patients Details**

<b>Title</b>		<b>Surname</b>		<b>First name(s)</b>		
<b>Date of Birth (dd/mm/yy)</b>	/	/	<b>Is this claim related to an accident ?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>
				<input type="checkbox"/>	<b>No</b>	

**3. Payment Details**

**Option 1 Payment to Policyholder/Insured**

<b>Payment to be made in:</b>	<b>Invoice currency</b>		<b>Other currency (Please specify)</b>	
<b>Preferred payment method</b>	<b>Bank Transfer (please complete bank details below)</b>			

Name of bank account

Account no. / IBAN

Swift Code

Bank Address

	Sort/branch code	
	Bank Name	

**Option 2 Payment to Provider of Medical Services (e.g. Hospital, Specialist, MRI)**

Please tick if Direct Billing has been previously agreed with Cega Air Ambulance Limited

#### 4. Patient Signature and Release

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Morgan Price International Healthcare Ltd, Cega Air Ambulance Limited or their appointed representatives.

**If a minor was treated, a parent or guardian should sign this section.**

Patient signature

Date (dd/mm/yy)

**TO BE COMPLETED BY THE TREATING DOCTOR IN BLOCK CAPITALS.**

#### 5. Medical Provider Information

Name of doctor/specialist 医師名

Qualifications/credentials 資格

Name of hospital/clinic 病院名

Address 住所


PostCode 郵便番号

PhoneNo. 電話番号

Email メール

	Country 国名	
	FaxNo. 番号	

Send completed form to : Morgan Price Claims, c/o Cega Air Ambulance Limited, PO Box 127, Chichester, West Sussex, PO18 8WQ, United Kingdom.

Claims Helpline +44 1243 621 224 Fax +44 1243 790265 E-mail [MP-Claims@cegagroup.com](mailto:MP-Claims@cegagroup.com)

## 6. Medical Information

Has Treatment Authorisation been obtained? 治療保障を受け取りましたか?	<input type="checkbox"/>	Yes (please attach details) はい	<input type="checkbox"/>	No いいえ
Indicate type of treatment received? どちらの治療を受けましたか?	<input type="checkbox"/>	Elective 通常来院	<input type="checkbox"/>	Emergency 緊急来院
Indicate type of condition どのように発病しましたか?	<input type="checkbox"/>	Acute 急性	<input type="checkbox"/>	Chronic 慢性
			<input type="checkbox"/>	Acute episode of a chronic condition 習慣的発病

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV  
病名又はコード番号


On what date did the patient first present these symptoms to you? 最初に来院した日	Date (dd/mm/yy) 日付 (日/月/年)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? 最初に症状がでた日	Date (dd/mm/yy) 日付 (日/月/年)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Are you aware of any treatment given for this or any related illness in the past? 以前、同じところを治療したことがありますか	<input type="checkbox"/>	Yes はい	<input type="checkbox"/>	No いいえ

If Yes, please give details :  
はいの場合、詳細を記入してください


Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details.

Name of referring physician	<input type="text"/>		
Telephone number	<input type="text"/>		
Date of referral (dd/mm/yy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Applicable to dental treatment only 歯科医師のみ

Was the patient suffering from dental pain at the time he/she visited you for treatment? 患者が来院したとき、痛みを訴えていましたか。	<input type="checkbox"/>	Yes はい	<input type="checkbox"/>	No いいえ
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Doctors Signature 医師のサイン	<input type="text"/>		STAMP
Date (dd/mm/yy) 日付 (日/月/年)	<input type="text"/>	<input type="text"/>	

The confidentiality of patient and member information is of paramount concern to us. Morgan Price International Healthcare Ltd and Cega Air Ambulance Limited fully comply with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

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