Globalwide
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CLAIM FORM

This International Claim Form must be completed for each member in full. Kindly ask your physician or service provider to complete the information in section 2 or attach an itemized bill.

Please send the completed, signed form, including any relevant medical documents, the itemized bill, and receipts to Globalwide via, our email address is: claim@globalwidehealth.com

Section | 1

1. Member's Information

Certificate no.	
First Name	
Surname	

2. Claim Information

a. Describe the condition (illness, injury, or symptoms requiring treatment)

b. What is the medical treatment received?

c. Date of treatment:

d. When did the first symptom of this condition begin?

[Within the last 30 days] [Within a few months] [More than a year ago]

e. Have you ever had or been treated for this type of illness before? [Yes] [No]

f. Are you currently taking prescription medication? [Yes] [No.] If yes, please specify

g. Is this condition caused due to an accident? If yes, complete the following:

(1) Date of accident:

(2) Location: At home / While driving / At work / Other

3. Member's Reimbursement Details

Should the reimbursement be sent to you directly, please specify the details of your bank account:

a. Name of the account holder:

b. Name of Bank:

c. Branch:

d. Account no.

4. Member's Confirmation

I hereby confirm that the information I provided herein above is correct.

Name: Signature: Date:

3010921

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Section | 2

[to be completed by the physician/provider; or attach an itemized bill]

1. Service Provider's Information

Service Provider's Name	
Specialty/Type of Provider	
Address	
Phone no.	

2. Claim's Information

a. Patient's condition: Acute / Chronic / Accident

b. Place of treatment: Clinic / Hospital (inpatient) / Hospital (outpatient) / E.R. / Lab

c. Date of treatment: _____

d. Describe the condition (including all symptoms):

_____

e. What is the diagnosis? Please also describe the treatment received (including names of suppliers, medications and prescriptions): _____

f. ICD9 and/or CPT code if available ICD CPT: _____

g. Medical history of current condition: _____

h. Recommendation for continuing treatment: _____

3. Payment Information

a. Payment received from the member: _____

b. Will you accept direct payment for the services provided? Yes / No. If yes, please attach payment information

4. Service Provider's Signature

Signature: _____ Date: _____