

Group Hospital & Surgical Claim Form

Instructions:

Please furnish the following documents within one month from date of discharge from hospital:

For hospitalisation in Government / Restructured Hospital:

- (1) Duly completed and signed claim form (Part 1)
- (2) All original final hospital bills, doctor's bills and receipts
- (3) Inpatient Discharge Summary
- (4) Inpatient Admission Report (if available)
- (5) Day Surgery Admission Form (if available)
- (6) Claim Statement from Medisave-approved Integrated Shield Plan (if any) –example, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

Please note we will reimburse up to \$75 for the medical report from Government / Restructured Hospital should we need the medical report to assess the claim.

For hospitalisation in Private Hospitals / Clinics / Hospitals outside Singapore

- (1) Duly completed and signed claim form (Part 1)
- (2) Medical Report by attending physician / surgeon (Part 2) – Medical report fee to be borne by claimant
- (3) All original final summary hospital bills, all original final itemised hospital bills, doctor's bills and receipts
- (4) Claim Statement from Medisave-approved Integrated Shield Plan (if any) –example, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

Group Hospital & Surgical Claim Form

Part 1

A. Employee's and Claimant's Details				
Policyholder (Employer)			Policy Number	
Insured Member (Employee)			NRIC / Passport No	Date of Birth
Occupation	Date of Employment	Plan No.	Sex F <input type="checkbox"/> M <input type="checkbox"/>	
Email Address		Contact Number Office: _____ HP: _____		
Claimant (Dependant)	Relationship Spouse <input type="checkbox"/> Child <input type="checkbox"/>	NRIC No / Passport No	Date of Birth	Sex F <input type="checkbox"/> M <input type="checkbox"/>
Is the dependant employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please furnish the name of employer:		Name and address of regular / family doctor		
B. Claims Details				
Diagnosis		Symptoms experienced		
Date symptoms first started		Date FIRST consulted doctor or took drugs		
Name & address of doctor FIRST visited for this condition		Was the illness due to employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you pregnant at the time of hospitalisation? (for female claimant) Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was the hospitalisation related to pregnancy, abortion, sterilisation, sub-fertility or infertility? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify condition and approximate date of commencement:		Had the illness been treated previously? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Type of operation performed, if applicable		1. If yes, please provide the name and address of the attending physician		
		2. Dates of previous treatments		
Date of Admission	Date of Discharge	Name of Hospital / Clinic		Name and address of attending physician
Was the hospitalisation / day surgery due to an Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date / Time of Accident		Place of Accident
Describe how the accident happened		Describe the injuries		
Was the Accident work-related? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you entitled to claim against Work Injury Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>		
C. Claims Payment Details				
Claim cheque to be made payable to: (please specify one only) Employer <input type="checkbox"/> Employee <input type="checkbox"/>				
D. Declaration and Authorisation				
We hereby authorise any doctor(s), hospital(s) or dentist(s) or other person who has / have attended to me / us, to disclose to HSBC Insurance (Singapore) Pte. Limited any and all information with respect to my / our medical conditions(s) / treatment(s). I / We also hereby declare that the information stated in this form are true and correct.				
_____ Employer's signature / Company's stamp / Date			_____ Employee's / Claimant's signature / Date	

Part 2: MEDICAL REPORT
(To be completed by the Attending Physician / Surgeon)

Name of Patient		Policyholder (Employer)	
Policy Number	NRIC No / Passport No	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

1a) Final Diagnosis	ICD Code :
b) Secondary Diagnosis	ICD Code :
c) Is the condition due to i) Hereditary conditions or congenital illness or abnormalities ii) Mental or Nervous or Psychiatric disorder iii) Treatment of teeth or gum tissue or oral cavity iv) Self-inflicted injury / drug addiction / alcoholism v) Job related injury vi) Sexually transmitted disease, AIDS and illness or disease related to HIV vii) Cosmetic purpose viii) Pregnancy, childbirth, miscarriage, abortion, impotency, sterilisation, sub-fertility or infertility. If for miscarriage, was it due to accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
d) Is the surgery medically necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2a) When did the patient first consulted you for the above condition / injury?	b) What was the complaint(s) when patient first see you?
c) How long had the patient been troubled by the symptoms prior to consulting you?	d) How long had this condition / injury been existed prior to consulting you?
e) Had the patient ever had same or similar condition / injury / symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If yes, when was the patient last treated for the condition / injury / symptoms?	f) Please specify the approximate date of discovery of the condition / injury.

3a) Was the hospitalisation / day surgery due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information:	
b) Date & Time of accident	c) Place of accident
d) Describe how the accident happen	e) Describe the injuries

4a) Was the patient being referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please the details below:		
Name of referring doctor	Date of treatments	Name of Hospital / Clinic & Address

5a) Period of Hospitalisation:		b) Surgical Procedure Performed (if applicable):				
Admission Date	Discharge Date	Surgical Procedure	Operation Code			Operation Table
Admission Date	Discharge Date	Surgical Procedure	Operation Code			Operation Table

c) Where was the surgical procedure carried out? <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic	d) Name of surgeon(s)
e) If more than one surgical procedure had been performed, were they done through the same incision? <input type="checkbox"/> Yes <input type="checkbox"/> No	f) If excision has been done, please indicate the size(s) / measurement(s) of the lesion(s) / tumour(s): (please attach a copy of the histology report)

Please **tick** the illness classification for the condition:

Alimentary system
 Autoimmune disorder
 Cancer/Malignant tumour growth
 Cardiovascular system
 Dental
 Ear, Nose & Throat system
 Eye
 Genito-urinary system
 Gynaecological / Obstetric
 Haematological disorder
 Infectious disease
 Metabolic & endocrine disease
 Musculo-skeletal system
 Nervous system
 Psychological / Psychiatric
 Respiratory system
 Skin and subcutaneous tissue

6a) Is the patient still under your care for the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	b) If patient had been referred to another doctor for follow up, please furnish the name and address of the doctor.
If yes, how long do you expect this to continue and when is the next review date?	
If no, please state date of termination	

c) Is the condition likely to relapse or require long term care? Yes No

_____ Signature of Physician / Surgeon / Date _____ Name / Designation	_____ Stamp of Clinic / Hospital
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