Notification of Claim of ☐ Hospital Admission ☐ Pre arrangement

Hospital: _____Tel: _____Fax: _____

Part 1 information of Insured person

Name-Surname_____ Age_____ Sex_____

Policy No. _____ Policy Commencement Date _____ Expiry Date _____

Admission Date _____Time _____ Room No. _____HN_____AN_____

1. I hereby permit and agree Pacific Cross Health Insurance PCL advance eligible medical expenses for the specified hospital in accordance with the benefits schedule. However, should at a later date it be proven that I am not eligible for medical benefits coverage, I agree to reimburse Pacific Cross Health Insurance PCL for the claims paid within 15 days of receiving notice. Also should I be eligible for medical benefits coverage from other insurance policies then I agree for the medical expenses to be shared between those insurance policies as well. Should the medical expenses be in excess of my insurance coverage then I agree to pay for the excess.

2. I hereby authorize any hospital or physician or third party who has rendered care to notify Pacific Cross Health Insurance PCL and reveal all information requested regarding to any illness or accident, past and recent medical history, or medical treatment to Pacific Cross Health Insurance PCL or its representative (Med-Sure Services Limited). I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured Person _____Date _____

(_____)

Part 2 for Attending Physician only

Initial Diagnosis and symptoms_____

When did the symptom first appear? _____

When and where did the patient first consult you for this condition?_____

Is the patient pregnant? ( ) Yes ( ) No Is the injury/illness as a result of an accident? ( ) Yes ( ) No

Diagnosis of condition for which hospitalization is required (please give details)_____

_____

Signature of Attending Physician _____ Date _____

(_____) License no. _____

If the Insured Person has any another insurance policies, social fund, or an act of legislation, please state_____

Please have estimate cost of this confinement _____ Baht, duration _____days

Part 3 for Med-Sure Services Limited Officer only

From the information provided above, Med-Sure Services Limited would like to inform the insured that

( ) can use the credit service

( ) deductible ……..…Baht, ( ) co-payment……%.

( ) pay for the medical treatment first, and then forwards all necessary documents for claim assessment

( ) use the eligible health insurance with

( ) social fund ( ) victim's act ( ) workmen's compensation act

( ) can not use the credit service because

( ) 30 days waiting period

( ) expired or cancelled insurance policy

( ) exclusion in the health insurance policy

_____

Please submit the following documents for claimsconsideration:_____

_____

IMPORTANT NOTICE

If additional hospitalization time and treatment is planned, you are required to immediately provide all necessary information to Pacific Cross Health Insurance PCL to justify the extended treatment period.