

Oracle Tower, Level 14, 56 Wakefield Street
PO Box 8672, Symonds Street
Auckland, New Zealand
Email: enquiries@interglobal-nz.biz
Web: www.interglobal-nz.biz

SECTION A – MEMBER DETAILS – TO BE COMPLETED BY MEMBER/PATIENT ONLY

If the patient is a dependant under the age of 18, the member is required to complete sections B to E

Surname:	First Name:
Date of Birth (dd/mm/yy):	<input type="checkbox"/> Male <input type="checkbox"/> Female
Plan Name:	Plan Number:
Personal Address:	
	Email:
Telephone Number:	Fax Number:

SECTION B – PATIENT DETAILS – TO BE COMPLETED BY MEMBER/PATIENT ONLY

Surname:	First Name:
Date of Birth (dd/mm/yy):	<input type="checkbox"/> Male <input type="checkbox"/> Female

SECTION C – FURTHER INFORMATION

Are you (or the patient) eligible for benefits under any other private medical expenses plan? Yes No

If yes, please complete the following details

Name if Insurer:	Plan Number:
Address of Insurer (if known):	

Is this claim the result of a third party accident? Yes No

If yes, please provide details of the Solicitor/Lawyer/Legal Counsel acting on your behalf

Name of Solicitor/Lawyer/Legal Counsel:
Address:

Did you contact the International Helpline? Yes No

Have you previously claimed for this medical condition? Yes No

If yes, please provide details:

Office use only:

Date received by InterGlobal Ltd:

SECTION H – MEDICAL INFORMATION

THIS SECTION IS TO BE COMPLETED BY THE DOCTOR/GENERAL PRACTITIONER/PHYSICIAN/DENTIST

Name of Doctor/General Practitioner/Physician/Dentist

Telephone Number:

Fax Number:

Please provide full details of the medical condition requiring treatment

Prior to consulting you, when did the patient first notice signs of this medical condition?

Date (dd/mm/yy):

On what date did the patient first present these symptoms to you?

Date (dd/mm/yy):

Please provide details of any treatment given to date for the condition described above

Applicable to dental treatment only

Was the patient suffering from dental pain at the time he/she visited you for treatment

Yes No

Please provide details of your prognosis based on the proposed course of treatment

In your opinion, would you consider the medical condition to be?

Acute Chronic

In your opinion, is the treatment for cosmetic reasons?

Yes No

Name of Specialist, including qualifications, to whom patient has been referred:

Date of referral:

Doctor's/General Practitioner's/Physician's/Dentist's practice stamp and address

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Doctor's/General Practitioner's/Physician's/Dentist's Signature:

Date (dd/mm/yy):

SECTION I – MEDICAL INFORMATION TO BE COMPLETED BY THE THERAPIST/SPECIALIST/CONSULTANT

Name of Therapist/Specialist/Consultant:

Telephone Number: Fax Number:

Has the patient been referred to you by a Doctor/General Practitioner/Physician/Dentist? Yes No

If yes, please detail full name and address:

Telephone Number: Fax Number:

Please provide full details of the medical condition requiring treatment

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? Date (dd/mm/yy):

On what date did the patient first present these symptoms to you? Date (dd/mm/yy):

Please provide details of any treatment given to date for the condition described above

Please provide details of your prognosis based on the proposed course of treatment

In your opinion, would you consider the medical condition to be? Acute Chronic

In your opinion, is the treatment for cosmetic reasons? Yes No

If physiotherapy is the appropriate treatment for this condition, please state how many sessions will be required:

Admission and discharge dates for all in-patient stays if known:

Name and address of Hospital:

Therapist's/Specialist's/Consultant's practice stamp and address

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Therapist's/Specialist's/Consultant's Signature: Date (dd/mm/yy):