National Health Insurance How to Complete the Form

Both you and the attending doctor must fill in the claim form for each individual visit or course of treatment.

You

- 1. The Patient's details section is to be filled completely including the NHI Number. Give us your contact details so we can keep you informed on the progress of your claim by Telephone or by e-mail.
 - Enter the bank details including the IBAN of the account where we can transfer your settled claim amount.
- Include the breakdown of expenses that need reimbursement.
 - Complete the summary table on the next page giving the full required details. Every invoice should be on one line.
- 3. Read the Declaration section carefully, tick the boxes and remember to sign and date the form.

Your Doctor

 Please ensure that the doctor completes each question of the Medical section in full and then signs and stamps it.

If you were unable to have the doctor complete the section, please provide the information to the best of your ability.

Reimbursement Claim I	nce Form T		NATION OF THE PROPERTY OF THE)
One Claim Form per person, family me For the required supporting documenta Before you submit, check your Table of Please write in BLOCK LETTERS, co	ation, use the atta of Benefits in you	ched Summary Table a or policy document for	exclusions to avoid rejection	
1. Member and Payment Details		Form Number		
Claimant Name		Employer	<u> </u>	
NHI Number	7	Mailing Address		
Gender Male	Female	Date of Birth		
Email Address		Phone Number ()	Day Ye	ar
Bank Name		Bank AC#		
Cheque Payable To		Branch	Route#	
2. Claim Details				
Is the claim in the US? Yes		If No. precise Country		
	J			
Name of Hospital / Dr2	-	Date of Treatment		-
Number of Invoices	med	Currency ible cover sheet to tabulate entrie		
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3. Medical Details - to be completed by the tr	eating Doctor			
	eating Doctor	If Yes, specify		
s it work related? Yes		If Yes, specify Day Care		
s it work related? Yes	No			
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Send your claim to:

NHI Claims Department

National Health Insurance P.O. Box 698 Road Town | Tortola British Virgin Islands Tel: 284 - 852- 7860

Claims Processing

Your claim will be assessed in full confidentiality by someone in the Claims Department. If NHI has received all required documents and information, you will receive reimbursement within 60 days along with an Explanation of Benefits.

It is preferred and recommended that the reimbursement claim form to be submitted within thirty (30) days of the date of service knowing that claims submitted after ninety (90) days of the treatment date shall not be accepted.

National Health Insurance Reimbursement Claim Form T

Name



Day

Year

One Claim Form per person, family members must apply individually For the required supporting documentation, use the attached Summary Table as cover sheet. Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections. Please write in BLOCK LETTERS, complete in full and submit within 30 days to ensure timely processing.

1. Member and Pay	ment Details		Claim Number			
Claimant Name NHI Number Gender Email Address Bank Name Cheque Payable To	Male	Female	Mailing Address Date of Birth Mi Phone Number (Bank AC#	onth	Day	Year
2. Claim Details						
Was service rendered	d in the BVI? Yes	No	If No, state which Co	untry		
Name of Hospital / Di		ount Claimed	Date of Treatment Currency	Month	Day	Year
Fe			ble cover sheet to tabulate e	ntries in chronolo	gical order.	
3. Medical Details –	to be completed by the	e treating Doctor				
Is it work related?	Yes	∐ No	If Yes, specify			
Treatment Type	In-Patient	Out-Patient	Day Care			
Chief Complaint						
Diagnosis						
Treatment Details						
I, the undersigned treating	doctor, hereby declare I ha	ve attended to this patient	and the particulars provided	are correct to the	e best of my kno	wledge.
Doctor Name		Signatui	re			
1 Declaration - Pleas	se read and tick all thre	se hoves helow		Mo	onth Da	y Year
Supporting Docur company or any c the complete, cor advice or hospitali Anti-Fraud - I, the misleading statem Insurance will hav	on – I, the undersigned, in the spenses paid by me, for the ments – I, the undersigned, ompany, institution or any crect and accurate informatization or any other informate undersigned, in the statement and/or information to crect the right to recover any or	ne stated capacity hereby de treatment of the claimant's in the stated capacity hereb other person who has any re on, including copies of their tion required by National He d capacity hereby declare t obtain reimbursement from I r all amounts that may have	eclare that the above informaticovered condition, for which read any doctor, hospitecord or information about the records with reference to an ealth Insurance. That I am fully aware that any National Health Insurance, is serimbursed or incurred under anding death or incapacity. A p	no previous claim cal, clinic, and/or le claimant to prov ny sickness or acc propersion, who intubject to penaliza the subject claim	has been applie health care provide National He ident, any treati centionally make ation. In such ev	d. rider, any insurance alth Insurance with ment, examination, es any false and/or ent National Health tion costs, if any.
be as valid as the original. The receipt of this reimburs	ement claim form/other su	oporting/related documents	does not constitute or be de	emed to constitu		

Reimbursement Claim Form Attachment Summary Table of Invoices

Mark the sequence number of the corresponding invoice.

Sequence Number	Service Date	Provider Name	Service Description	Diagnosis	Invoice ref. Number	Claimed Amount
hecklist - Befor	e you submit, pleas	se check that you have included all c	of the following as applicable:	7		
Completed and	signed Reimbursem	ent Claim Form		7		
Pre-approval le	tter form National He	ealth Insurance where required (Overse	as Care)			

Checklist - Before you submit, please check that you have included all of the following as applicable:	✓
Completed and signed Reimbursement Claim Form	
2. Pre-approval letter form National Health Insurance where required (Overseas Care)	
3. Doctor's Referral (Local and Overseas)	
4. Original invoices/bills showing payments confirmation	
5. Medical and/or Lab test reports (including MRI/CT Scan and Operating Reports)	
6. All claims submitted must be in original & translated to English for the settlement	
7. Summary Table of Submitted Invoice (above) completed	
8. You have retained a copy of the Form, Summary Table and original invoices and report for your reference	

If Pre-approved not received, give a reason why.		