HOSPITALISATION & SURGICAL CLAIM FORM

**(NTU / NIE Claim Form)**

**IMPORTANT NOTES:** It is important to read the notes below before you complete the claim form.

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| **PREPARING REQUIRED DOCUMENTS**  Please complete this form in **FULL** and email the following documents to [claims@raffleshealthinsurance.com](mailto:claims@raffleshealthinsurance.com) within 30 days of discharge from the hospital/ treatment date:   * Copy of Final Summary and Itemised Hospital Bills. * For Government Restructured Hospitals: Copy of Inpatient Discharge Summary / Day Surgery Discharge Form / Histology Report * For Overseas Hospitals / Private Hospitals / Clinics: Copy of Attending Physician’s Statement (refer Page 4 and 5) * Please note that this form is **NOT** an acceptance of your claim. * Please note that incomplete submission of documents may delay the processing of your claims. |
| **TYPE OF ENTITIES** |

Nanyang Technological University (Undergraduate, excludes Singaporean)  Nanyang Technological University (Non-Graduating)

Nanyang Technological University (LKCSoM)  Nanyang Technological University (NIE)

Nanyang Technological University (Graduate)  Nanyang Technological University (NIEI)

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| **CONTACT US** | **TYPE OF CLAIM DOCUMENTS REQUIRED (CHECK LIST)** | |
| **RAFFLES HEALTH INSURANCE PTE LTD**  (Registration No. 200413569G)  25 Tannery Lane  Singapore 347786  Tel: 6286 2866  Fax: 6812 6615  **Email:** [claims@raffleshealthinsurance.com](mailto:claims@raffleshealthinsurance.com)  **Website:** [www.rafflesmedicalgroup.com/ntu-ghs](http://www.rafflesmedicalgroup.com/ntu-ghs)  **Our Operating Hours:**  Monday to Friday 9.00am-6.00pm  Closed on Saturdays, Sundays and Public Holidays | **Hospitalisation and/or Surgical**  Completed Claim Form  Copy of Final Hospital Bill (the hospital will usually send the final bill to the patient about 2 to 3 weeks after discharge)  Copy of Pre and Post Hospitalisation/Surgery Bills  Copy of Discharge Summary/Day Surgery Authorisation Form  LOG Request Form (if request for LOG) | **Outpatient Specialist, A&E, Physiotherapy, TCM or Mental Health**  Completed Claim Form  Original Medical Bills  Copy of Referral Letter from A&E or Fullerton Health @ NTU |

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| **SECTION 1: PARTICULARS OF INSURED** | | | | |
| Name of Student (please write in capitals, as per bank account)  Click or tap here to enter text. | | | Address (Singapore)  Click or tap here to enter text. | |
| Gender  F M | NRIC/ FIN No.  Click or tap here to enter text. | Date of Birth  Click or tap to enter a date. | Email Address  Click or tap here to enter text. | |
| Matriculation No.  Click or tap here to enter text. | | Matriculation Date  Click or tap to enter a date. | Expected Date of Graduation/ Completion of Course  Click or tap to enter a date. | Mobile/Telephone No.  Click or tap here to enter text. |

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| **SECTION 2: OTHER INFORMATION** (Please DO NOT state the bank details of another person) | | | |
| *Reimbursement for approved claims will be credited into the student’s bank account*  Click or tap here to enter text.  **Please select one for claim payment:**  Telegraphic Transfer  Giro (provide details below)  *For Telegraphic transfer, all administrative costs from the bank will be chargeable to the student.* | | | |
| Name of Account Holder  Click or tap here to enter text. | Name of Bank  Click or tap here to enter text. | Name of Intermediary Bank  Click or tap here to enter text. | Account No.  Click or tap here to enter text. |
| Bank Address Including Branch (*For Telegraphic Transfer*)  Click or tap here to enter text. | | Swift Code/ IBAN (*For Telegraphic Transfer*)  Click or tap here to enter text. | |

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| **SECTION 3: DETAILS OF ILLNESS OR INJURY** | | | | | | |
| **A. Hospitalisation due to Illness** |  |  | **B. Hospitalisation due to Injury from Accident** | | |  |
| Nature of Illness/Final Diagnosis  Click or tap here to enter text.  Describe Symptoms and date symptoms first appeared  Click or tap here to enter text.  Type of Operation performed (if applicable)  Click or tap here to enter text. | |  | Describe how it happened and state the extent of the injury (Please enclose a copy of the police report, if any.)  Click or tap here to enter text. | | | |
| Date illness first treated/Date of first consultation  Click or tap to enter a date. | Name of doctor/hospital the patient first consulted for the illness  Click or tap here to enter text. | | Date of Accident  Click or tap to enter a date. | Time of Accident  (HH:MM) | Place of Accident  Click or tap here to enter text. | |
| Is the illness job-related? *(for working spouse only)*  Is the illness due to pregnancy, miscarriage or fertility? | | No Yes  No Yes | Is the injury/accident job-related? *(for working spouse only)*  Is it claimable under Workmen’s Compensation? *(for working spouse only)* | | | No Yes  No Yes |
| Are you making a claim from any other insurance companies?  No  Yes, please provide information below:  Name of insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*** Please submit a copy of the other insurance company’s claim settlement letter or payment voucher | | | | | | |

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| **SECTION 4: Declaration & Consent** |  |
| **PERSONAL DATA NOTICE**   1. I understand, acknowledge, agree and consent that Raffles Health Insurance Pte Ltd (**“RHI”**) or its representatives are permitted to: 2. collect, use, disclose and/or process my personal information set out in this form and any other personal information provided by me or from other sources such as employer, intermediaries, medical organisations, third party providers or agents (which may be sited outside of Singapore), other insurance companies (collectively the **“Personal Information”**) for the purpose(s) set out below; and/or 3. disclose and transfer such Personal Information to other sources such as other departments in RHI, employer, intermediaries, medical organisations, banks, CPF Board, reinsurers, third party service providers or agents (which may be sited outside of Singapore), other insurance companies, for the purpose(s) set out below: 4. **Purpose(s)**    1. processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims;    2. investigating the accident and/or my claims;    3. carrying out and/or dealing with my instructions or responding to any enquiries by me;    4. administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes / mail packages); and/or    5. complying with applicable law in administering, processing, handling and/or dealing with my claims. 5. I further acknowledge and consent that my Personal Information may be collected, used and/or disclosed by RHI for: 6. carrying out due diligence activities in accordance with legal or regulatory obligations or risk management procedures required by law or the Monetary Authority of Singapore (**“MAS”**) or implemented by RHI; 7. responding to requests for information from other insurance companies, MAS, General Insurance Association of Singapore (**“GIA”**), Life Insurance Association of Singapore (**“LIA”**) or other relevant government agency/authority (such as police).   **DECLARATION & AUTHORISATION**   1. I hereby declare that the information on this form and any documents attached to it is correct and complete and I have not withheld any information that could affect this claim. 2. I hereby authorise any hospital, physician or other person who has attended to me to furnish Raffles Health Insurance Pte Ltd or its representatives all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records. 3. I agree that a photocopy of this authorisation shall be considered as effective as the original. 4. I undertake that the invoice(s) are as received from the service providers. 5. I understand that RHI reserves the right to request for original bills / certified true copies. 6. I understand that RHI reserves the right to reject any claim, recover any amounts disbursed from duplicate or fraudulent claims and impost additional charges, as necessary, for claims made against the contract. | |

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| **X**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature & Name of Patient  Date: Click or tap here to enter text. | | **X**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature & Name of Parent  (Parent to sign if patient is below 21 years old)  Date: Click or tap here to enter text. | |

**Attending Physician’s Statement**

( To be completed for patients seeking treatment at Overseas Hospitals / Private Hospitals / Clinics )

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| Name of Patient  Click or tap here to enter text. | Date of Birth  Click or tap here to enter text. | NRIC / FIN / Passport No  Click or tap here to enter text. | Gender  F  M |

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| **SECTION 1: Details of Illness / Injury** | | | | | |
| Final Diagnosis of illness or extent of injury   |  |  |  |  | | --- | --- | --- | --- | | ICD Code |  |  |  |   Click or tap here to enter text.    What was the cause of the illness / injury?  ( If due to an accident, please furnish date of accident )  Click or tap here to enter text. | When did the patient first consult you for this condition?  Click or tap here to enter text.  What was the patient’s complaint or symptoms presented during the first consultation?  Click or tap here to enter text. | | | | |
| How long has the illness / symptoms been existing prior to consulting you?  Click or tap here to enter text. | | | | |
|  | | | |  |
| Is the condition / treatment related to: | | **No** | **Yes** | If ‘**Yes’**, please elaborate: |  |
| 1. Congenital Anomaly / Birth Defect / Genetic / Hereditary Disorder? | |  |  | Click or tap here to enter text. |  |
| 1. Dental / Gum Treatment / Oral Mucosal? | |  |  |
| 1. Pregnancy / Childbirth / Abortion / Miscarriage / Birth Control / Infertility? | |  |  |
| 1. Cosmetic / Aesthetic Treatment? | |  |  |
| 1. Correction of Eye Refraction? | |  |  |
| 1. Emotional / Stress / Psychiatric / Psychological / Sleep Disorder? | |  |  |
| 1. Attempted Suicide / Self-Inflicted Injury / Alcoholism / Drug Addiction? | |  |  |
| 1. Natural / Physiological Menopause? | |  |  |
| 1. Developmental Delay / Learning Disability? | |  |  |
| 1. STD, AIDS or infection by HIV? | |  |  |
| 1. Human Papilloma Virus (HPV)? | |  |  |
| 1. Has the patient been treated by other doctor(s) for this illness before consulting you? If ‘Yes’, please state when and the name of doctor, and name and address of clinic.   Click or tap here to enter text. | | | | |  |
| 1. Was the patient referred by any of the above doctors?  No  Yes | | | | |  |
| 1. Did the patient suffer similar or related conditions in the past? If ‘Yes’, please state when, nature of problem, name and address of attending doctor and dates of treatment.   Click or tap here to enter text. | | | | |  |

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| **SECTION 2: Details of Surgical Procedures & Treatment** | |
| Surgical operations performed on patient   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Operation Codes\*** |  | **Type of Operation** |  | **Tables\*** |  | **Date Performed** | | Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. | | Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Where was the operation / Surgical Procedure(s) performed? |  | Hospital | Clinic |  | Name of Surgeon | | Were the surgical procedures approached through the same incision? |  | Yes | No |  | Click or tap here to enter text. | | If excision was performed, please indicate the size / measurement of the lesion / tumour |  | Click or tap here to enter text. | |  | Name of Anaesthetist | |  |  |  | |  | Click or tap here to enter text. | | |
| If no surgery was performed, was the admission for diagnostic purpose?  Click or tap here to enter text.  Please state the reason for admission and treatment and medication rendered during the admission.  Click or tap here to enter text. | |
| Is the patient still under your care for the condition?   |  |  | | --- | --- | | No. Please state date of termination | Click or tap here to enter text. | | Yes. How long do you expect to continue? | Click or tap here to enter text. | | When are you going to review the patient again? | Click or tap here to enter text. | | If patient has been referred to another doctor for follow-up, please furnish name and address of doctor.  Click or tap here to enter text.  Is the condition likely to relapse or require long term care?  Yes  No |

\* For surgery done in Singapore based on Tables of Surgical Operation for Medisave scheme, 1 Feb 2021**.**

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| **SECTION 3: Doctor’s Certification** |

**Declaration**

I …………………………………………………………………………. the undersigned, do hereby declare that I was the doctor in attendance during the last illness of ………………………………………………………………….and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

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| Name of Doctor | Click or tap here to enter text. |  | Signature |  |
| Name of Clinic / Hospital | Click or tap here to enter text. |  | Professional Qualification | Click or tap here to enter text. |
| Clinic / Hospital Stamp |  |  | Date | Click or tap to enter a date. |