Guarant	tee for	Medical	Expenses
Caaran		1. ICulcul	Expenses



To be completed by the treating facility

Are you: 1. Applying to recover a	e you: 1. Applying to recover expenses incurred (<\$500)									
2. Making an application for a guarantee of payment (\$500+)										
Patient's First Name:	Patient's Surname:									
Patient's Date of Birth:	(DD/MM/YYYY)	Patient's Nationality:								
Check valid coverage on www.expatriate.claims	What Excess is stated?*									
Have you seen original identification? Yes	No	Туре:	Reference:		(OBTAIN COPY)					
Have you seen their Membership Card? Yes	No	Do the credent	tials match ID?	Yes	No (OBTAIN COPY)					
Diagnosis:										
Date of Diagnosis:	(DD/MM/YYYY)	Sympton	ns:							
On what date would the first onset of symptoms have been apparent to the patient? (DD/MM/YYYY)										
Treatment plan:										
Will treatment plan: Cure underlying condit	Alleviate symptoms	e symptoms (not cure)								
Medicine(s) for			medicine(s)							
current condition:		taken by	v patient:							
Medical history:										
Referring Doctor	Attendin	Attending/Admitting Doctor								
Name:	Name:									
Referring Facility:		Treating Facility:								
Email: (MANDATORY)		Email:(Mandatory)								
Telephone:	Telephone:									
(INCL. COUNTRY & AREA CODES) (INCL. COUNTRY & AREA CODES)										
Please sign, date and authenticate with an official stamp.										
I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.										
Doctor's signature:			Official Stamp:							
Address:										
Outlifesting			Data							
Qualifications:		Date:		(DD/MM/YYYY)						

Please ask the patient to visit www.expatriate.claims to begin their online claims application. This will need to be completed to enable settlement of bills associate with any treatment received.

* Please note that the excess is the patient's responsibility and will need to be settled directly to you and deducted from the final bill.

Return the completed Guarantee for Medical Expenses Form, invoices, proof of payment of the Excess (if applicable) and any supporting medical reports, X-rays, etc, to: Email: claims@expatriategroup.com Fax: +44 870 428 5141





Please note:

- 1. The patient is responsible for payment of the excess and proof of payment is required.
- 2. If the treatment is for physio or covered 'alternative' treatments, then a GP referral letter is required.
- 3. The customer will be required to complete an online claims request at www.expatriate.claims to complete the process.

Expatriate Group, Delmon House, 36-38 Church Road, Burgess Hill RH15 9AE, United Kingdom t +44 (0)20 3551 6634 e info@expatriategroup.com w www.expatriatehealthcare.com