Claim Instructions

Outpatient Claims

In most circumstances, clients will settle the charges for consultation, laboratory, or pharmacy with the providers and submit claims for reimbursement.

Patients should ensure that bills include required information from the doctor's office, laboratory, or pharmacy for the claim to be considered. Here is a summary of the basic details required:

- name of the patient
- date of treatment
- doctor's name and professional qualifications
- country where treatment took place
- the amount paid by the patient
- an explanation of the services rendered and the charge for each
- the diagnosis or other reason for the visit

A laboratory and pharmacy bill should normally be submitted with the bill from the doctor who prescribed/ordered it. If not, the client should submit a copy of the prescription, a doctor's report or a fully completed claim form (Sections A, B & C), showing the diagnosis and date(s) of treatment.

For simple outpatient treatments, the client only needs to fill in Section A & B (front) of the claim form. Where the claim is more complicated or where treatments are expected to continue, the client should ask his or her physician to complete Section C (back) as well. It is difficult to list all outpatient claims which may fall into this category, but some examples are:

- special diagnostic tests such as CT scan, MRI, Stress Test, endoscopy, allergy testing, x-ray, blood work, referred to other medical professionals etc.
- where surgery or hospitalization is involved or anticipated
- if multiple outpatient visits, or physiotherapy/chiropractor/acupuncture treatments will be required
- in cases involving accidental injury (see below for further instructions)

Hospital/Surgical Claims

Claims for surgery, or for treatment in a hospital, casualty ward or emergency room, must be accompanied by a fully completed Claim Form (Sections A, B & C) and complete medical reports.

In case of hospitalization or surgery, GlobalHealth may be able to in settling hospital bills directly. Contact should be made directly to GlobalHealth, or via designated emergency service provider. Direct billing network provider is not under this limit but subject to pre-approval.

Letter of Guarantee (LOG)

Clients requiring hospital guarantee should contact GlobalHealth as soon as the need for hospitalization/surgery arises. Both sufficient information and clear instructions as to what the client requires should be given to expedite handling of the request. In general, at least three (3) working days are required to arrange non-emergency hospital guarantee, particularly outside of Asia. Late or incomplete requests may affect our ability to provide service.

In cases of medical emergency, guarantee or prepayment of hospital deposits may be available from designated emergency service provider. Please refer to the designated emergency service provider program rules for details.

Indemnity Form signed by the Policyholder or the patient may be required before LOG be issued.

In case of Accident or Injury

The member should provide GlobalHealth with a statement written by the member giving full details of how the accident occurred (including date, time, and place). GlobalHealth may also require other documentation, such as a police report.

Filing Period

Claims must be submitted within 90 days of the date of service unless it is shown that it was not reasonably possible to file within this time. Claims not submitted within 12 months of the date of service will not be entertained under any circumstances.

NOTE: In some cases your policy may have special terms and conditions on accessing particular medical facilities. Always check your policy documents for any specific limitations on your cover

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