AIR NIUGINI SAVINGS & LOAN SOCIETY LTD

Your Key for a Better Future *www.angsl.com.pg*

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MEDICAL OUT-PATIENT CLAIM FORM *(Reimbursement)*

A. PATIENT INFORMATION

Patient ID: _____ Patient First Name: _____ Patient Last Name: _____

Contact Phone Number: _____ Relationship to Insured Employee

Policy Number: _____ Policy Holder (Employer): _____ ☐ Self ☐ Spouse ☐ Child ☐ Parent

Insured Employee ID: _____ First Name: _____ Last Name: _____

REASON FOR REIMBURSEMENT:

☐ Emergency case at Non-Network Provider ☐ Without Network Provider in the area

☐ Service(s) not available at Network Provider ☐ Other. Please specify: _____

CLAIM REIMBURSEMENT OPTIONS:

☐ Bank Transfer

Bank Account Holder's Name: _____

Bank Name: _____

BSB Code: _____ Account No: _____

☐ Cheque

Cheque Payee Name: _____

B. MEDICAL TREATMENT (to be completed by Attending Doctor)

Diagnosis - Nature of Illness/Injury _____

Nature of Procedures done, if any (Please describe fully) _____

Has the Patient been previously treated for the above-mentioned condition: ☐ Yes ☐ No

If "Yes", please provide details:

Name of Doctor	Date of Treatment	Reason for Treatment	Nature of Treatment/Results

For Dental treatment: is the Patient a Betel Nut User as evidence by red gum and stained teeth? ☐ Yes ☐ No

If "No", please provide photographic evidence (picture of open mouth) ☐ N/A

C. DOCTORS DECLARATION

I hereby declare that the information given on this form is true to the best of my knowledge and beliefe.

_____ _____

Signature of Attending Doctor Date

D. PATIENT'S DECLARATION AND AUTHORIZATION

I regularly use Betel Nuts (please tick one): ☐ Yes ☐ No

I hereby declare that the Patient information given on this form is true to the best of my knowledge.

All personal information obtained herein is collected for the purpose of (i) assessing, processing, evaluating and determining requests of medical claims or services referral and (ii) analysing, investigating, approving and/or determining claims submitted and will be transferred to PHA and/or its third-party administrator (TPA).

I hereby authorize the transfer of data to PHA and/or the TPA for the administration of medical services. I further understand that withholding such consent shall relieve PHA to deliver such services.

D. PATIENT'S DECLARATION AND AUTHORIZATION

Approved ☐ Not Approved ☐ Approval Code: _____

Date Received: _____ Date Issued: _____ Approved by: _____