

Please complete clearly in BLOCK CAPITALS.

### A- Patient Details

To be completed by main member/patient only

Title:  Mr.  Mrs.  Miss  Ms Other:

First Names: Family Name:

Date of Birth (dd/mm/yy): Sex:  M  F

Group Name (if applicable): Member Number: Plan Number:

Symptoms/Conditions requiring visit:

I declare that all the details provided on this claim form represent a true and accurate statement and that I have not omitted any details pertinent to the circumstances of this claim. I understand that in the event that this claim is found to be fraudulent in whole or in part, I am committing a criminal offence and that this will invalidate the plan and render me liable to prosecution under P.R.C Law. In respect of any medical claim I hereby authorise any Medical Practitioner, Specialist, Consultant, Therapist or other relevant establishment who has previously attended me/or is currently attending me/patient, to provide any details that may be requested by Royal & Sun Alliance (R&SA).

Patient's/Member's Signature:

Date (dd/mm/yy):

### B- Medical information

To be completed by attending medical practitioner, consultant/specialist or dentist

Prior to consulting you, when did the patient first notice signs and symptoms of this medical condition? Date (dd/mm/yy):

1. Please provide full details of the medical condition requiring treatment:

Has the patient suffered from the same or similar symptoms previously?  Yes  No  
If yes, please provide details of previous episodes, including dates:

2. Investigations required  LAB  Radiology  Other

Please provide details:

3. Applicable to dental treatment only

Was the patient suffering from dental pain at the time he/she visited you for treatment?  Yes  No  
Was the dental treatment?  Routine  Emergency

4. Diagnosis of the medical condition

Treatment advised: Rx: Rx:  
Rx: Rx:  
Is a follow up visit required  Yes  No  
If yes, please confirm when (dd/mm/yy):

5. If physiotherapy is the appropriate treatment for this condition, please state how many sessions will be required: \_\_\_\_\_

6. In your opinion, would you consider this condition to be?

Acute  Chronic  Acute episode of a chronic condition

7. In your opinion, would you consider the treatment to be for cosmetic reasons?  Yes  No

Medical Practitioner/Specialist/Consultant/Therapist/Dentist practice stamp or name and address:

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Medical Practitioner/Specialist/Consultant/Therapist/Dentist Signature: Date(dd/mm/yy):