CTG

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Medical Claim Form

IMPORTANT INFORMATION

Please fill out the form in BLOCK CAPITAL letters and ensure that all sections of this claim form are fully completed with to avoid delays in processing your claim. This form should be returned to CTG within two (2) months of the initial treatment date and should be before the end of your consultancy agreement with CTG .

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PATIENT DETAILS

Staff ID Number

Date of Birth

Full name

Age

Current address

Email address

Country of residence

Mobile number

Date of the treatment

What is the total amount of the claim?

In which country did the treatment take place?

Will there be any further treatment (follow up) for this claim?

☐ Yes | ☐ No

What is the currency of the invoice?

MEDICAL DETAILS

Medical Practitioner's details:

Name of the doctor

Contact number

Medical facility name and address

Email

Diagnosis

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MEDICAL DETAILS CONTINUED

If admitted in the hospital:

Admission date

Discharge date

Treatment details (information of the treatment)

Operations details (information of the operation)

Medication details (information of the medication)

Notes

FOR PRE-EXISTING CONDITION TREATMENT

Have you ever had or been treated for the same kind of illness or injury? Yes | No

Please provide the full details

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DECLARATION

Please check the boxes to confirm the below declarations:

☐ I confirm that the information I have given on this form is accurate and correct, to the best of my knowledge.

☐ I understand and agree that in order to process insurance requests and/or organise medical evacuations, CTG may need to obtain medical information (including medical records and reports) from the doctor that attended me. All medical information (including medical records and reports) shared by my doctor and/or medical provider is solely for my own convenience and benefit and will take place under conditions in which my health is under risk.

☐ I consent CTG to obtain medical information (including medical records and reports) from my doctor on my behalf to share it with the insurance provider, if appropriate.

Patient's signature
(Signature is not required if you have completed this form electronically.)

Date

If you have any queries regarding your claim, please contact CTG Field Liaison Office by email at medical@ctg.org, by whatsapp or call at +971551024968, or talk to our Field Liaison Officer through skype (ctghqflo).

IMPORTANT NOTES

- Please ensure your bank details are correct and updated on MyCTG. Claim reimbursement will be transferred on the bank account stated on your profile on MyCTG. Should you need assistance in updating your MyCTG, please contact your CTG account Manager
- Please send the the following documents together with this claim form to **medical@ctg.org** and put your complete name in the subject line of the email:
  - Discharge summary (if applicable). A document prepared by the attending physician that summarises the admitting diagnosis, diagnostic procedures performed, therapy received while hospitalised, clinical course during hospitalisation, prognosis, and plan of action upon the patient's discharge with stated time to follow up. The document should be signed and stamped by the attending physician.
  - Diagnostic tests and reports
  - Invoices, bills, receipts
  - Doctor's prescription and treatment charges
- We can only accept claims if the treatment has already happened. If it's taking place in the next 30 days, you can request pre-authorisation to make sure you are covered.
- Make sure the documents are in a clear, readable format and only display the details relevant to a single member per claim.