

Private medical insurance claim form



Please make sure that you read the following BEFORE completing the claim form:

- Confirmation of cover will be provided when we have made a decision on your claim. If you have any treatment or investigations and cover has not been confirmed this will be at your own risk, as cover may not be available.
- If your GP charges for the completion of this claim form, we do not pay this cost unless your claim is covered by the policy.
- The appropriate medical professionals must complete Section 4 of the claim form. If you are unsure as to who is to complete the claim form, please contact us.
- Other useful information about making a claim can be found in your policy documentation.

Please complete all relevant sections in BLOCK CAPITALS

1. Patient details

Full name	<input type="text"/>	Policy number	<input type="text"/>
Company name (if a company policy)	<input type="text"/>		
Full address	<input type="text"/>		
	<input type="text"/>		
	Postcode: <input type="text"/>		
Email address	<input type="text"/>		
Date of birth	<input type="text"/>		
Telephone numbers: home	<input type="text"/>	work	<input type="text"/>
mobile	<input type="text"/>	Email	<input type="text"/>

2. Medical details – to be completed by the patient (or parent or guardian if patient is under 16 years old) IF GP HAS COMPLETED A REFERRAL LETTER PLEASE ENCLOSE A COPY

Please give details of the symptoms you have been experiencing:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
How long have you been experiencing these symptoms? Please give dates	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Have you had any symptoms similar to this or in the same area before? Please provide full details of symptoms and dates	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Have you sought advice from ANY medical professional regarding these symptoms previously? Include private GP, pharmacist, physiotherapist, chiropractor etc. Please provide full details including names and dates	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

3. GP details

GP's name	<input type="text"/>	
Name and full address of GP's surgery	<input type="text"/> <input type="text"/> <input type="text"/>	
Telephone number of GP's surgery	<input type="text"/>	Fax <input type="text"/>
GP email address	<input type="text"/>	
Full name of specialist that the patient has been referred to	<input type="text"/>	Practice Manager name <input type="text"/>
Hospital where specialist holds NHS consultancy post	<input type="text"/>	

4. Medical details (to be completed by the GP or dentist)

Please note that all information needs to be clear, precise and accurate, and all sections must be completed in BLOCK CAPITALS.

When do the patient's records begin?

Current episode

Please describe the condition/symptoms the patient is suffering from

When did the patient first make contact with the surgery regarding these symptoms? (For example, when was the first appointment made?)

What was the date of the first appointment?

How long has the patient been aware of these symptoms/this condition?

History of these symptoms/this condition

Please provide a full history of the condition – this must include dates of all consultations/advice/treatment (including prescriptions). Please use additional paper if required

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

How long before the FIRST EVER visit did the patient have symptoms?

Related symptoms/conditions

(Our definition of related is: Diseases, illnesses or injuries are related if, in our reasonable medical opinion, one is a result of the other or if each is a result of the same disease, illness or injury).

Please provide a full history of any **related** symptoms/conditions – this is to include dates of all consultations/advice/treatment (including prescriptions). Please use additional paper if required.

How long before the first visit did the patient have **ANY RELATED SYMPTOMS**

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Is there a referral letter? Yes No **(Please tick as appropriate) If yes, please attach a copy**

I declare that to the best of my knowledge and belief the information given in this medical section is true and complete. I understand that failure to provide accurate information may result in, but is not restricted to referral to your relevant authority (GMC, responsible officer, NHS England or similar).

Signature of GP/dentist		Date	/ /
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Print name	
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5. Other insurer involvement/Third party claims

Other private medical insurance company

If you also have private medical insurance cover with a company other than Aviva, you will need to complete this section. When a person has two policies that may cover them, they can only claim eligible medical costs once. If you are included on another policy that provides medical cover, the cost of your treatment may be split between Aviva and the other company.

You do not need to do anything except provide the information requested – we will deal directly with any other company involved.

If you are covered by another private medical insurance company, we need to know the following:

- **name, full address and contact details for the other company**
- **policy number**

Other medical company	

Third party

This is when you have an illness or injury and you require medical treatment for which you are claiming from Aviva, as well as claiming costs against any person or company who may be responsible for that illness or injury.

The details we need for these cases are:

- **Your solicitor's name, address, telephone number and reference number (if you have appointed a solicitor)**
- **The name of the person who may have been responsible for your illness or injury, and their insurer's name, address, contact details and policy number.**

Third party involvement (please give all third party details known to you)	

6. Consent to obtain a medical report

We may require further information from your doctor to enable us to make a decision on your claim. We can only obtain this with your consent and therefore need you to sign and date the 'Consent and declaration' section on the next page.

You should be aware that you have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. The main points of the Act are as follows:

- a) If you indicate (in the declaration below) that you don't wish to see the report we won't let you know if we apply for one. If you decide that you want to see the report, before it is sent to us, you can write to your doctor within 21 days to make arrangements to see it.
- b) If you indicate (in the declaration below) that you do want to see the report, we'll write to you at the same time we contact your doctor. We'll let the doctor know that you'd like to see the report; you then have 21 days to contact your doctor to make arrangements to see it. When you've seen the report your doctor might not send it to us until you've given consent to do so. If you don't contact your doctor within 21 days the report will be sent to us.
- c) You can ask your doctor if they'll amend any part of the report which you consider to be incorrect or misleading. If your doctor isn't in agreement, you may attach your comments to the report.
- d) You can ask your doctor to see a copy of the report up to 6 months after we've received it. If you ask for a copy of your report your doctor may charge you a fee to cover the cost.
- e) In some circumstances the doctor may decide, in the interest of your health, or to respect the interest of others, that you shouldn't see all or part of the report. The doctor will notify you of this and you'll have the right to see any remaining part of the report. If it's the whole of the report which is affected, this won't be given to us without your consent.
- f) You can withhold your consent (in which case we may be unable to proceed with your claim).

7. Consent and declaration

Please read the declaration and complete the boxes below:

I have read the section about my rights under the Access to Medical Reports Act 1988 (or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991). I agree to the provision of any and/or all of my medical records to Aviva in connection with this claim.

By signing below, I give my permission to any institution or person (including, but not limited to, hospitals, doctors, nurses and health professionals) who has been involved in my treatment both past and present, to provide Aviva (and third parties acting on its behalf) with any information, including full medical records, reports or notes, concerning my physical or mental health.

I DO NOT wish to see the report before it is sent to Aviva (please delete if you wish to see the report before it is sent to us).

If you do not consent to Aviva obtaining a medical report, please tick this box

I declare that, to the best of my knowledge and belief, the information given on this form is true and complete.

Signature of patient (or signature of parent or guardian, if patient is under 16 years old).

Signature

Date

Print name

This consent will only apply to this claim and will last until your policy ends. If you wish to specify an expiration date for this consent or to extend to all claims, please state here:

Consent to discuss details with another person

At Aviva we are aware that some circumstances may mean you need to ask someone else to manage your policy or update your claim. Due to data protection rules, we require your consent to be able to take instructions from others, so if you would like us to be able to discuss your claims & policy administration queries with a family member or someone else please complete the below section.

For information:

- Policy administration - includes but is not limited to, change of address/name **For individual policies only** it would also include but is not limited to, level of cover/benefit options/premium payment options.
- Claims - includes but is not limited to initiating and updating claims.

Please note, by giving consent to speak about claims would mean discussing sensitive medical information. Consent for claims and policy administration would be for the duration of the policy with Aviva, unless you specify otherwise and will apply to the policy that you have stated above. You can withdraw this consent at any time or make amendments by contacting us. On occasions even with the completion of this form, we may need to clarify/verify certain details with the actual member if there is any uncertainty to the information provided.

The person you wish to authorise

Title

First name

Last name

Date of birth

Relationship to you

Email address

Contact number home/work/mobile

What are you giving consent for (Please tick all boxes that apply) Policy administration Claims Specific Claim
Claims Reference Number

If you wish to specify an expiration date for the consent given, please state here

Your signature &

Date

Next Steps

Please sign the consent and declaration box and return this form with any enclosed invoices and third party claim details to:

Customer Service Department
Aviva Health UK Limited
Chilworth House Hampshire Corporate Park
Templars Way
Eastleigh
Hampshire
SO53 3RY or email avivapmiclaims@aviva.com

Once we have received all the necessary medical information for your claim, we aim to reach a decision within five working days. If we need further information, or there are likely to be any delays, we'll get in touch with you on one of the telephone numbers you have given us.

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aviva.co.uk/health

