



# Medical information form

Here to help

+44 (0) 1892 556274

Available day or night, 365 days a year

## Please send your completed form to:

Upload or secure email via:

axappinternational.com/members

Fax: +44 (0) 1892 508256

Post: International Customer Service

AXA PPP International, Phillips House, Crescent Road, Tunbridge Wells, Kent, TN1 2PL, UK

Please help us to review your claim quickly by writing clearly

## There are three parts to this form:

### Part

### Who needs to complete this part

A: Claim Details

the patient making the claim

B: Patient Consent

the patient making the claim

C: Medical Details

the patient's Doctor or Medical Practitioner

## Part A: Claim details

To be completed by the patient

### A1 About you and your claim

Please remember to use **BLACK INK** and write in **BLOCK CAPITALS** throughout

Full name and title

Address

Please give full address details, including postal code and country where applicable.

Membership/customer number

Claim number (if known)

Contact details

Please include country and area codes, where applicable.

Please give the Parent or Legal Guardian's details if the patient is under 16.

Telephone

Email

Date of birth

D	D	M	M	Y	Y	Y	Y
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Reason for claim

Please describe the symptoms or medical condition being treated

Continued on the next page

## A2 Claim payment details

Have you already paid any bills for the treatment you're claiming for?

- ☐ No – Please go to section A3  
☐ Yes – Please complete the rest of this section

We'll pay for any treatment you're covered for directly into your bank account

Please attach all invoices or receipts and / or proof that you have paid for the treatment as well as any medical certificates, correspondence or documents relevant to the claim. To avoid any delays with your claim, please make sure you list:

- ☒ The dates of the treatment      ☒ The type of treatment  
☒ The medical condition      ☒ The invoice value

Currency for claim to be paid in

IBAN (if relevant to your bank's location)

Country

SWIFT or BIC code

Bank account number

ABA number

Payee name

Bank name and address

Account name

If you have further treatment planned, please contact us on +44 (0) 1892 556274 or online by following the instructions at [axappinternational.com/members](http://axappinternational.com/members)

## A3 Further information

Do you want to claim a cash benefit for treatment received free of charge?

- ☐ No  
☐ Yes – If yes, please send confirmation of the dates of your stay or treatment with this form and proof that the services were provided free of charge.

Is the treatment following an injury or accident?

- ☐ No – Please go to section B  
☐ Yes

a. Do you feel that someone else was at fault and caused the accident or injury?

- ☐ No  
☐ Yes

b. Do you have another insurance policy that would also cover your claim?

- ☐ No  
☐ Yes – Please give details

Other insurer details

# Part B: Member Consent

To be completed by the patient

I confirm I have read the information in this form.

I declare that all the information I have given you is, to the best of my knowledge, true and correct.

- I consent to AXA PPP healthcare reviewing the information on this form.
- I consent to AXA PPP healthcare requesting medical information, if needed, from the patient’s medical practitioner and/or hospital.
- I consent to the medical practitioner and/or hospital providing medical reports and access to copies of such health records as may be requested by AXA PPP healthcare. This is so that AXA PPP healthcare can:
  - a. deal with the application/exclusions;
  - b. undertake audits and other investigations; and
  - c. process and share medical information with third parties where there is a legal requirement to do so.
- I consent to AXA PPP healthcare reviewing the information in any medical reports or health records that may be requested.
- I consent to the medical practitioner, and/or hospital involved in the patient’s care reviewing medical or treatment details and discharge arrangements with AXA PPP healthcare.
- I agree that AXA PPP healthcare will send all further correspondence about this to the policyholder, unless I ask you not to.

I declare that I am the patient

- ☐ Yes
- ☐ No

Is the patient under 16 years of age?

- ☐ No
- ☐ Yes

If yes, I declare that I am the patient’s parent/guardian

- ☐ No
- ☐ Yes

I wish to see any report from the medical practitioner before it is sent to you

- ☐ No
- ☐ Yes

Signed\*

*\*If the patient is under 16, this form must be signed by their parent/legal guardian*

Date

D

D

M

M

Y

Y

Y

Y

Patient’s full name

# Part C: Medical Information

To be completed by the patient's medical practitioner – please help us by writing clearly

Patient Name

Date of birth

D	D	M	M	Y	Y	Y	Y
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How long has this patient been known to you?

Are you the patient's usual primary-care physician?

☐ No

☐ Yes

Do you have access to the patient's medical history?

☐ No – See below

☐ Yes

If no, please tell us the name and address of the person who holds the patient's medical history file

## C1 Medical Details

Medical condition / Diagnosis

ICD Code

Surgical Code (if appropriate)

Description of Symptoms

How long have symptoms existed prior to consulting you?

When did the symptoms first start?

D	D	M	M	Y	Y	Y	Y
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If there are no symptoms, what prompted the patient to see you?

Given the aetiology of the condition, how long do you think the condition has been present?

Date of first treatment or consultation with any provider

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Date of treatment with you

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Type of investigation required to confirm diagnosis

Further treatment plan (if any)

Was the patient referred to you by another medical practitioner?

☐ No

☐ Yes – If yes, please provide name and contact details of referring medical practitioner

Is the claim related to or as a result of any previous surgery or treatment?

☐ No

☐ Yes – If yes, please detail, including dates

Continued on the next page

Does the patient have any associated or related medical conditions?

- ☐ No  
☐ Yes – *If yes, please state and explain the relation and date of diagnosis*

  
  
  
  
  
  


Does the patient suffer from any other significant medical condition(s)?

- ☐ No  
☐ Yes – *If yes, please list the medical condition(s) and the date of diagnosis*

  
  
  
  
  
  


Has the patient received any previous consultation(s)/treatment or hospitalisation for this condition, associated conditions or symptoms and/or other conditions?

- ☐ No  
☐ Yes – *If yes, please detail*

Date of treatment

       

Medical condition/treatment

  
  


Provider name

  
  


Is the patient taking any medication for this condition?

- ☐ No  
☐ Yes – *If yes, name of drug and date of starting medication*

  
  
  
  
  
  


If the claim relates to pregnancy, is the pregnancy a result of natural conception?

- ☐ No  
☐ Yes

If the claim relates to pregnancy, is this the patient's first pregnancy?

- ☐ No – *If no, please detail any previous complications of pregnancy*  
☐ Yes

C2

Medical Practitioner Declaration

I am the patient’s medical practitioner and confirm that the information I have provided is correct to the best of my knowledge. I understand that, if any of the information is incorrect, this may affect my patient’s claim for private healthcare expenses

Signature

Contact telephone number

Print name

Date

D

D

M

M

Y

Y

Y

Y

Email address

Practice Stamp

**Please remove this 'Important information' page and keep it for your information**

## Data Protection Act 1998:

**Information about your health, medical history and any treatment that you have is sensitive personal information.**

- Usually we need your consent to process your sensitive personal information.
- For a small fee you can get a copy of the information we hold about you. We may need to get your doctors' or medical practitioners' consent to give certain medical information to you.
- If you believe that any information is wrong you can ask us to change it. We will either change it or explain to you why we won't do this.
- You may ask us, in writing, for a copy of any personal information contained in any report that we may ask from an independent doctor.
- You should contact your own doctors for any report that they produce.
- Claims information may be processed in confidence on our behalf, outside the European Economic Area.
- The lead member is the legal holder of the healthcare plan and we will therefore send emails or letters about the plan including letters or emails about a claim to the lead member.
- If you don't want the e to know about your condition you should not claim under the plan.
- If we receive medical records, and identify a medical condition that should have been declared on the plan application, we will use that information to amend the underwriting terms of the plan.

## Access to Medical Reports Act 1988:

The Access to Medical Reports Act refers to your rights that we need to make you aware of before you agree that we can ask for a report from your general practitioner or any specialist treating you. This Act doesn't relate to reports from practitioners who are not responsible for treating you, but you can ask us for the personal information contained in any independent reports (see Data Protection above).

These rights also don't apply when we ask your GP or specialist for copies of information from your medical records, although you can always withhold your consent for us to ask for this information.

- You can withhold your consent, but if you do so, we might not be able to pay your claim.
- If we request a report we'll write to you to tell you the date that we did this.
- You have 21 days from the date of our request to contact the doctor and arrange to see the report before the doctor sends it to us. It's up to you to contact the doctor. You can ask the doctor to see the report anytime within six months of the doctor issuing it. The doctor can charge you for a copy of the report. The cost of this is not covered by your plan.
- If you disagree with any of the information in the report you can ask the doctor, in writing, to change it. If the doctor doesn't agree with you, they will invite you to write a statement of your view, which will be attached to the report.
- If you tell us that you don't want to see the report and then change your mind before the doctor has sent it to us, you can write to your doctor who will give you access to the report.
- You will have 21 days from the date of your request to see the report. The sooner we receive the report, the sooner we can deal with your claim.

## Exemptions in the Access to Medical Reports Act 1988

- Your doctor doesn't have to show you any part of the report if doing so would, in the doctor's opinion, be likely to cause serious harm to your physical or mental health or which reveals the doctor's intentions in respect of you.
- If a report reveals information about someone else, the doctor won't show you that part of the report.
- If any exemption applies, the doctor will tell you this in writing, but you can still see any part of the report not covered by the exemptions.

## Auditing and prevention of crime

We audit the records of medical practitioners, hospitals and so on to:

- ensure that they're charging our members correctly for the services they've received,
- prevent and detect crime, particularly fraud,
- assess the performance of healthcare providers.

This helps us keep subscriptions at appropriate levels. Audits may be part of a programme or in response to specific circumstances.

To help prevent and detect crime we also carry out other investigations including reviewing members' medical and other health records held by the person or organisation being audited, before and or after treatment.

We may pass information directly to third parties or by using shared databases. These third parties may include medical experts, other insurers, the NHS Counter Fraud Security Management Service, the General Medical Council and law enforcement agencies. This is to prevent or investigate crime, including fraudulent or other improper claims. In some circumstances we must give information about our suspicions of crime to law enforcement agencies. We must let the relevant regulatory body know when we have good reason to question a healthcare providers fitness to practice.

## Integrated healthcare for group health schemes

If you're a member of a company healthcare scheme your employer may also provide or use our Occupational Health Service and/or Employee Assistance Programme. These services are provided by separate companies.

With your consent we and these companies will share sensitive and/or personal information, in confidence on an ethical need to know basis to provide you and your employer (in the case of Occupational Health Services and the Employee Assistance Programme), with support and advice about your health.