Accident and Health Claims Department

 # Medical Expense Claim

1. The Original Receipt including Itemized bills or Statement or Interim bill
2. Medical Report or Medical Certificate which specifies injuries and cause, treatment period
3. Copy of Police Daily Report (if any)
4. Copy of Insured's National ID Card or passport
5. Copy of Bank Account (Saving Account)
6. Completed Compensation Claim Form (A01)

Remark:

1. All Claims must be translated in ENGLISH and/or THAI language ONLY.
2. Reimbursement process normally takes up to 7-15 working days from the date we received completed claim documents, however, this is not included suspended claim in case we require further information from you or provider for our reviewing.

Dhipaya Insurance Public Company Limited

DHIPAYA CLAIM FORM

Insured Person Details

1. Name of insured ……………………………………………………………………..Sex. ………Age. …….. Occupation ……………………….
   Address …………………………………………………………………………………………………Telephone number……………………………
   Policy no. ………..

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2. For Health Claim and Hospital Benefits Claim (Please attach a copy of book bank with certified the document.)

Bank Name…………………………………………………………………………Branch………………………………………………………………
Account Name……………………………………………………………………Bank Account ……………………………………………………

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3. Illness

( ) OPD ( ) IPD ( ) ICU ( ) Others ……………………………………………………

3.1 Hospital's name …………………………………Admission Date …………………………Discharge Date …………………………
3.2 Present illness/Details of injury ………
3.3 Duration of symptoms ……
3.4 Attending Doctor ………
3.5 Diagnosis ……
3.6 Treatment ( ) Medication ( ) Surgery ……………………………. ( ) Others …………………………………………………………
3.7 Others ……

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4. Accident / Incident / Loss Details

4.1 Place of Accident ………
4.2 Date & Time of accident ………
4.3 Describe how the accident occurred ……
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4.4 Present illness/Details of injury ………
4.5 To Notify the Police? ( ) No ( ) Yes Date ……………………… Police station's name ………………………………………
4.6 Hospital's name ……
4.7 Attending Doctor ……
4.8 Last date of treatment………..
4.9 Investigation by (Lab)………….(X-Ray)……………..(CT scan)…………(EKG)……………(Other)…………………………….
4.10 Clinical finding ………
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4. For Female: Was the patient pregnant at the time of treatment? ( ) No ( ) Yes……………..weeks

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5. Are you making any other Insurance or Compensation Claim as a result of this injury? ( ) No ( ) Yes

Name of company ……
Amount of compensation………………………………………………………………Baht

I hereby authorized any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all Information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all or medical records, a photo static copy of this authorization shall be considered as effective and valid as the original

Sign Here………………………………………………..Claimant Date …………………………………………………