Lippo Insurance
Protecting Your Family

William Russell

Direct Billing Claim Form

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Section A

Section A is to be completed by the claimant or the claimant's guardian or legal representative.

Your personal details

Full name: ....

Plan number (if applicable): .... Email: ....

Mobile number: .... Home number: ....

Medical information

Have you previously suffered from this or from any related condition? ◯ Yes ◯ No

Declaration and authorisation by claimant

I hereby give William Russell authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition(s) and financial payment information. I accept that my personal details may be passed to selected third parties for the sole purpose of assisting the administration of my claim. If the claimant is unable to complete this declaration, the claimant's guardian or legal representative may do so.

Signature of claimant: .... **Date:** ....

Section B

Section B is to be completed by the claimant's treating Doctor.

Patient's details

Full name: ....

Nationality: .... Date of birth: .... ◯ Male ◯ Female

Was the patient referred to you? ◯ Yes ◯ No

If YES, please state the name and contact details of the referring physician: ....

....

....

Dates of treatment received

Please confirm the date the patient first registered at your facility/practice: ....

On which date did the patient first consult you for this particular condition? ....

Please give a short description of the patient's symptoms/injuries: ....

....

....

In your professional opinion, for how long before this date would the patient have been aware of their symptoms? ....

....

....

Your diagnosis

What is your clinical diagnosis? ....

....

....

Please give details of any tests performed and attach the test results: ....

....

....

Your treatment plan

Please provide a treatment plan including details of medications currently being prescribed to the patient: ....

....

....

....

....

Medical information

Has the patient previously suffered from this or from any related condition? ◯ Yes ◯ No

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred: ....

....

....

Declaration by treating doctor

I declare that I am the patient's treating Doctor, and that the details given above are, to the best of my knowledge, full, true, accurate, and complete.

Signature of treating Doctor: .... **Date:** ....

Print your name and address: ....

....

....

.... Email: ....

Telephone number: .... Fax number: ....

Qualifications: ....

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP:

Contact details
T +62 21 9067 9339
E enquiries@william-russell.co.id
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The international health insurance plans are insured and issued by PT Lippo General Insurance Tbk, a company registered & administered by Otoritas Jasa Keuangan. The plans are designed by William Russell Ltd, a company authorised & regulated in the UK by the FCA, reference number 309314.