EMERGENCY CLAIM FORM

Membership Number / Expiry Date

In accordance with the Health International Terms & Conditions, as stated in the Membership Guide Section 10, any Member visiting a medical facility for the purpose of EMERGENCY treatment is required to do the following:-

A. **NOTIFY THE REGIONAL OFFICE WITHIN 72 HOURS OF THE EVENT** (by telephone / email / text / visit).

B. **COMPLETE THIS EMERGENCY CLAIM FORM AND SUBMIT TO THE CLAIMS DEPARTMENT** (see details below).

C. **MEMBERS ARE REMINDED THAT SHOULD THIS CASUALTY VISIT BE A NON-EMERGENCY / OUT-PATIENT CLAIM, IT MAY BE DECLINED. IF YOU ARE UNSURE, KINDLY CALL THE CLAIMS DEPARTMENT ON THE FOLLOWING NUMBER +260 (0) 966 853 948.**

Failure to comply with the above will lead to repudiation of the claim.

MEMBERS INFORMATION: (As Per Your Health International Membership Card)

Name of Principal Member:

Contact Telephone No: Mobile:

Full Name of Patient:

Patient Date of Birth: DD / MM / YYYY

Membership No: Membership Expiry Date:

COMPLETION OF THIS SECTION IS COMPULSORY:		
REASON FOR EMERGENCY VISIT: Please Tick The Applicable Box	☐ **ACCIDENT**	☐ **ILLNESS**
DATE OF EMERGENCY:	**TIME OF EMERGENCY:**	
FULL DESCRIPTION OF THE EMERGENCY:		

Name of Emergency Facility:

Name of Treating Doctor or Specialist:

(PLEASE INCLUDE CONTACT DETAILS IF AVAILABLE)

INVESTIGATIONS RELATED TO THE EMERGENCY:		
RADIOLOGY (X-RAY / MRI SCAN / C.T. SCAN ETC.)	☐ YES	☐ NO
PATHOLOGY (BLOODS / SPECIMEN URINE / STOOL ETC.)	☐ YES	☐ NO

Member's Signature ________________ Date (DD / MM / YY) ________________ Place: ________________

I understand that Health International will collect and process my personal data as per Clause 9.10 of the Terms and Conditions.

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