LUMA
57 Park Ventures Ecoplex 9th Floor,
Unit 912 Wireless Road,
Lumpini, Pathumwan, Bangkok 10330 Thailand

Tel: + 66 2 494 3600

Luma
Brighter Health.

REIMBURSEMENT FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and a FULLY COMPLETED CLAIM FORM. All documents will be handled in strict confidence by our medical team.
Failure to provide the required information may result in your claim not being settled.Thank you.

1 PATIENT INFORMATION

First/Familyname	:	Card No.	:
Address	:	Email	:
Tel. No.	:	D.O.B. / Age	:

2 BANK DETAILS (COMPULSORY)

Account Holder Name	:		
Account Number / IBAN	:		
Bank Name	:		
Bank Address	:		
Currency	:	SWIFT Code	:

3 MEDICAL INFORMATION (to be completed ALL by the Physician)

1. Chief medical complaints:

2. When has the patient first noticed the symptom(s)?:

3. What is the final diagnosis and the cause of the condition?:

4. Has this condition been triggered by underlying pathologies?
- ◯ No
- ◯ Yes, please specify:

5. From a medical standpoint, when do you think this condition may have started?:

6. Has patient been treated earlier and then referred to you?
- ◯ No
- ◯ Yes, please provide the name of hospital/clinic or the referring doctor:

7. Recommended treatment plan:

4 PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries/illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature : _____

Date : _____

Stamp

5 PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish Luma information with regard to any medical history, condition or services.I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature : _____

Date : _____

Hospital Contact (24/7)
Thailand +662 494 3677
Vietnam +84 (0) 190 055 8864
Cambodia +855 (0) 89 766 111
Myanmar +95 (0) 978 625 5905

Email : cs@lumahealth.com
Fax : +662 108 2207

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Claim Submission Check List

Required claim documents to be submitted for claim reimbursement;

- ☐ Original Receipt
  - ✓ Service provider's name
  - ✓ Patient's name
  - ✓ Date of service
  - ✓ Detail of cost
  - ✓ Total amount
  - ✓ Cashier's signature
- ☐ Original Medical report/certificate
- ☐ Completed & Signed Reimbursement Form/Claim Form
- ☐ Detailed Breakdown of charges (statement detail report; name of medicine and price of each items to be mentioned)
- ☐ Doctor's prescription (with medical indication for prescription drugs, laboratory tests, physical therapy, eyeglasses and contact lenses)
- ☐ Signed Copy of Bank Book (1st page) (unless provided)
- ☐ Signed Certified Copy of ID card / passport of Insured (unless provided)

Practical Advice:

1. Please make copies of all documents sent

2. Send us your claim within 1 month following the medical service.