LUMA

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

Tel: + 66 2 494 3600



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. $\label{provide} \mbox{Failure to provide the required information may result in your claim not being settled.} \mbox{Thank you.}$

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 No		
by underlying pathologies? Yes, please specify:		
5. From a medical standpoint, when do you think this condition may have started?:		
6. Has patient been treated earlier \(\subseteq No		
and then referred to you? Yes, please provide the name of hospital/clinic or the referring doctor:		
7. Recommended treatment plan:		
4 PHYSICIAN DECLARATION	5 PATIENT DECLARATION	
I hereby certify that I have personally examined and treated the insured for	I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any	
his/her injuries/illness described above and that the facts stated above represent my medical opinion of his/her condition.	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 :	Signature :	
Stamp		

Date:

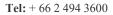
Hospital Contact (24/7)
Thailand +662 494 3677
Vietnam +84 (0) 190 055 8864
Cambodia +855 (0) 89 766 111
Myanmar +95 (0) 978 625 5905

Date:

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.