Mapfre Malta p.l.c.
Middle Sea House, Floriana FRN 1442 Malta

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info@mapfre.mt
Registration Number: C5553

Health Insurance Claim Form

Read carefully before you submit your claim:

- Claims must be submitted within 3 months of your first treatment date.
- Treatment must be undertaken and given by, and under the control of your attending specialist or general practitioner.
- Specialist referral is mandatory for hospitalisation, CT and MRI scans, and alternative treatment.
- Treatment by physiotherapists and mental healthcare professionals must be GP or specialist referred.
- Professional fees are reimbursed in line with the Schedule of Approved Healthcare Provider Fees, available on our website.
- A separate claim form must be submitted for each patient and each medical condition.

Refer to the Health Policy or contact us on healthclaims@mapfre.mt before your treatment if you need more information.

Please submit your claim for reimbursement on https://www.mapfre.com.mt/health-claims/.

1. INSURED DETAILS

Policy no:		Group/Company name:
Title:	Name:	Surname:
I.D. card/Passport no:		Date of birth:
Address:		

2. PATIENT DETAILS

Title:	Name:	Surname:
I.D. card/Passport no:		Date of birth:
Mobile no:	E-mail:	

3. REASON FOR SEEKING MEDICAL ADVICE

Symptoms/diagnosis:		
Date when the symptoms were first noticed:	Date of first consultation:	Date of last consultation (if applicaple):
For hospital admissions only (attach hospital documents)	Admission date:	Discharge date:
If any of the costs are recoverable from a third party, please give details.		

4. BANK ACCOUNT DETAILS

We will pay the claimant if they are 18 or over; otherwise, payment will be made to the policyholder. The eligible payee must be the bank account holder. Full IBAN details are required; otherwise, settlement will be held pending receipt of this information.

Use the bank details below for this and future claims YES ☐ | NO ☐		
Bank account holder full name:		
IBAN:		
Bank Name:	Bank Branch:	BIC/SWIFT Code:

5. CLAIM DETAILS - *To be completed by the GP/specialist*

Patient name:	Date of first consultation:
Symptoms and diagnosis:	
Treatment details:	
GP / Specialist name and signature:	Date:

To be completed by healthcare professionals complementary to medicine.

Symptoms and diagnosis:	
Treatment details:	
Treatment provider name and signature:	Date:

DECLARATION

I declare that the information provided in this form is true, complete, and correct to the best of my knowledge and belief and I accept full responsibility for the statements made. I understand that if any material information is withheld or incomplete, Mapfre Malta p.l.c. may reject the claim.

If this form has been completed by someone else on my behalf, I confirm that the information reflects my statements and that the contents have been fully explained to me.

I understand that, for the purpose of assessing, validating and managing this claim, Mapfre Malta p.l.c. may request and receive medical information from any doctor, hospital, clinic, laboratory, insurance company or other professional who holds records about me or my dependants. I authorise these individuals or entities to disclose and release such information to Mapfre Malta p.l.c. where necessary for these purposes.

PERSONAL DATA PROCESSING

If you would like to know more about how Mapfre Malta p.l.c. processes your personal data, please refer to the following link: www.mapfre.com.mt/privacy-policy/.

Date:
Patient's signature (if the patient is under 18, the policyholder must sign):