

AMERICAN INTERNATIONAL ASSURANCE CO., LTD.

Group & Credit Life Insurance Department

1 Robinson Road #11-00

AIA Tower

Singapore 048542

Fax: 6538 4340 or 6538 5603 Email: group-claims.aia_sgp@aig.com Website: <https://gmd.aia.com.sg>**OUTPATIENT CLAIM FORM****Mediguard/Clinical/Specialist**

1. This form is for filing of claims for:

Treatment at Government Polyclinics
Emergency Outpatient Treatment at Accident & Emergency Department of Hospitals in Singapore <ul style="list-style-type: none"> Weekdays: Consultation between 9 pm & 7 am Weekends: Consultation between 1 pm on Saturday & 7 am on Monday
Specialist Outpatient Treatment (if applicable) <ul style="list-style-type: none"> with referral letter from a registered general practitioner
Treatment at Non-panel Clinics

- Claims should be submitted within **20 days** with original bills and receipts. Original bills and receipts must show the patient's name, date of treatment, diagnosis and must have the attending physician's stamp and signature.
- Claims for Specialist Outpatient Treatment or X-rays/laboratory tests must include a copy of the attending physician's referral letter.
- Claims for purchase of drugs must include a copy of the attending physician's prescription.
- Claims for Emergency Outpatient Treatment at Accident & Emergency Department due to accident resulting bodily injury, please give a brief description of accident, date and time under the special instruction/remarks field.

Name of Employer					Group Policy No. GHS		
Name of Insured Employee					Certificate/NRIC No.		
<input type="checkbox"/> Giro: Employee's Bank: Branch:..... Account no.:..... <input type="checkbox"/> Cheque. Employer's Name					Participation Date MMDDYY		
Type of Claim (please indicate): <input type="checkbox"/> Treatment at Polyclinic <input type="checkbox"/> Emergency Outpatient Treatment <input type="checkbox"/> Overseas Outpatient Treatment <input type="checkbox"/> Treatments at Non-panel Clinic <input type="checkbox"/> Specialist Outpatient Treatment <input type="checkbox"/> Others:					Expiry Date MMDDYY		
FOR AIA USE ONLY							
Date of Consultation (MMDDYY)	Name of Patient	Ee/ Sp/ Ch *	Details of Claim/Diagnosis	Amount	Dep Code	Claim No.	Adjusted Amount
Special Instructions/Remarks							

*Ee: Employee / Sp: Spouse / Ch: Child

Date

Employee's Signature

Employer's Signature/
Company Stamp