



Customer Care Centre
 AXA Tower Lt. GF
 Jl. Prof. Dr. Satrio Kav.18, Kuningan City
 Jakarta 12940, Indonesia
 Tel : 1500 733
 Fax : +62 21 3005 9008
 Email : customer@axa-insurance.co.id

Claim Form SmartCare Executive



Important

1. Please complete this claim form and attached all related claim document refer to Claims Document Requirement on page 2.
2. Submit to the SmartCare Executive program administrator within 30 days after discharged from hospital or medical treatment.
PT Administrasi Medika, Jl. Balikpapan Raya No. 11B, Kelurahan Petojo Selatan, Kecamatan Gambir, Jakarta Pusat 10160
UP. CLAIM DEPT. Tel. 1500 353 Fax. (+6221) 3483 0903

Personal Data

Insured's Name	:	Card member no	:
Date of Birth	:	Plan	:
Gender	: <input type="checkbox"/> Male <input type="checkbox"/> Female	Job title	:
Address	:	Telephone	:
	:		
Company Name	:	Telephone	:
Address	:		
	:		

For claim payment purposes, please complete the data below			
Bank Name	:	In the name of	:
Branch	:	A/C No.	:
Total paid	:		

Authorisation to Release Information

*I hereby authorise PT Asuransi AXA Indonesia and any other third party appointed by the Insurer without any time limit to obtain any information/medical records from hospital/clinic or other party acquired in the course of my examination or treatment or my family's medical history for the purpose of the settlement of my health insurance claims according to the applicable law and regulation.. Copy of this statement and letter of authority has the same validity with the original Letter of Authority which is irrevocable during the enforcement of this **SmartCare Executive** Programme. I declare that to the best of my knowledge and belief, all information under this is true and correct.*

 Name & Signature

 Place & Date (D/M/Y)

MEDICAL RESUME (must be completed by Physician)

1. Date of treatment :/...../..... to/...../..... (dd/mm/yy)
2. Registration No. :
3. Name of hospital/clinic :
4. Is the hospital/clinic listed as our provider ? Yes No
5. Type of treatment : Inpatient Dental Consultation
 Outpatient General Consultation Maternity
 Outpatient Specialist Consultation Optical (For optical benefit, please ignore item no. 4 till 9)
6. Anamnesis :
7. Physical Check Up :
8. Support Check Up :
9. Diagnosis :
10. Therapy :
11. Medical Advice :

 Physician's name, signature, and hospital/clinic stamp

 Place

 Date/Month/Year

(C048e 10/16)

Claims Document Requirement

No	Document Requirement	Type of Claim					
		In patient	Out patient	Accident	Hospital Cash	Death	Coordination Benefit
1	Original completed claim form <i>(filled by client)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Completed medical resume <i>(filled by treating doctor, signed & stamped by Hospital)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Copy of laboratory examination result & radiology/ other diagnostic examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
4	Original receipt with details of medication fee, treatment fee & copy of prescriptions <i>(for the claim amount 1mio and above must be stamp IDR 6000)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-	-
5	Photocopy of Passport <i>(if treatment/dies at overseas)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	-
6	Copy of Insured / Participant ID Card <i>(for Group)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Power of Attorney to request medical data	<input type="checkbox"/>	-	-	<input type="checkbox"/>	-	-
8	Photocopy of driver license & investigation report from the Local Police <i>(if an accident)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	-
9	Original receipt with details of medication fee, treatment fee, copy of prescriptions & copy of examination diagnostic result <i>(only if there is a coordination of benefit & hospital cash plan)</i>	-	-	-	<input type="checkbox"/>	-	<input type="checkbox"/>
10	Copy of insurable Interest between Insured and Beneficiary(s)	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	-
11	Copy Beneficiary(s) ID <i>(only for death claim allowance)</i>	-	-	-	-	<input type="checkbox"/>	-
12	Power of Attorney from Beneficiaries if Beneficiaries more than one person / Certificate of heirs	-	-	-	-	<input type="checkbox"/>	-
13	Legalized of Death Certificate from authorized institution	-	-	-	-	<input type="checkbox"/>	-
14	Legalized of Death Certificate from General Consul of RI <i>(if dies at overseas)</i>	-	-	-	-	<input type="checkbox"/>	-
15	Death of Chronology <i>(if dies at home or when go to Hospital)</i>	-	-	-	-	<input type="checkbox"/>	-
16	Bank account Power of Attorney <i>(if the account owner is not the Benefit Receiver)</i>	-	-	-	-	<input type="checkbox"/>	-
17	Insured Death of Certificate which has been authorized by legal Institution, States the Insured has been died, if the Insured was miss in accident	-	-	-	-	<input type="checkbox"/>	-
18	Result Visum Repertum and investigation report from Local Police <i>(if dies due to accident)</i>	-	-	-	-	<input type="checkbox"/>	-
19	Original receipt of the excess of the treatment <i>(only if there is a coordination of benefit and for claim amount 1mio and above must be stamp IDR 6000)</i>	-	-	-	-	-	<input type="checkbox"/>
20	Statement letter with detail of claim payment from another Insurer/BPJSK <i>(only for coordination of benefit)</i>	-	-	-	-	-	<input type="checkbox"/>

Note: Required
 - Not Required

*For claim amount up to Rp. 1 million can be submitted through WA at 0815 8670 7637 or MyAXA Health application.
 For further information, please contact our Customer Care.*