ORP
CLINICAL CLAIMS
RESOLUTION PROCESS

CLINICAL CLAIMS RESOLUTION PROCESS

CCRP Secretariat
Tel No: 6593 7877
Email: application@ccrp.com.sg
URL: http://www.ccrp.com.sg

Please complete and submit this Application form to the CCRP Secretariat. Please carefully read all terms and conditions governing this Application and related matters. Incomplete submissions will not be considered.

REQUEST FOR DETERMINATION (RFD) APPLICATION FORM

To: **CCRP Secretariat**
Academy of Medicine, Singapore

Date of Application	
CCRP Reference No. *(For Official Use)*	

SECTION 1: DECLARATION & AGREEMENT

(√)	**Contractual Agreement** *Please ensure that you have read and completed this section before you proceed.*
	(1) We, the Applicant and the Respondent, hereby agree to seek a final and binding determination of our dispute that is within the scope of the Clinical Claims Resolution Process.
	(2) We confirm that we have met the prevailing requirements for the dispute to be referred. We confirm that the dispute is not already the subject of court, arbitral, regulatory, criminal or other adjudicatory proceedings.
	(3) In consideration for the CCRP Secretariat processing this Request and the Panel members making a determination of our dispute, we agree to be bound by the **CCRP Rules (Annex A)** in force at the time the determination commences and we agree to be bound by the determination or amended determination (if any) issued to us. We agree that there shall be no appeal from the determination or amended determination (if any).
	(4) The Applicant will pay to the Academy of Medicine, Singapore the prevailing fee for the determination. The determination commences only upon receipt of payment.

SECTION 2: SUMMARY OF DISPUTE

Brief description of dispute by the Applicant *Each party to submit a written statement setting out its full position on the determination sought, together with all relevant documents.*

SECTION 3: APPLICANT & RESPONDENT DETAILS

APPLICANT	RESPONDENT
APPLICANT CATEGORY	**RESPONDENT CATEGORY**
NAME OF APPLICANT **(NAME OF REPRESENTATIVE IF APPLICANT IS NOT AN INDIVIDUAL)**	**NAME OF RESPONDENT** **(NAME OF REPRESENTATIVE IF RESPONDENT IS NOT AN INDIVIDUAL)**
INSTITUTION (NA. if Not Applicable)	**INSTITUTION**
EMAIL ADDRESS	**EMAIL ADDRESS**
MOBILE NO / OFFICE NO	**MOBILE NO / OFFICE NO**
MAILING ADDRESS	**MAILING ADDRESS**
SIGNATURE (MAY USE DOCU-SIGN)	**SIGNATURE (MAY USE DOCU-SIGN)**

IMPORTANT

1. Please **do not submit** the originals of your documents to CCRP. You should only provide scanned copies of the documents supporting your application in PDF format via email to application@ccrp.com.sg.
2. By signing this Application Form, the Applicant and Respondent **reaffirm their consent** to Rules 8 (Confidentiality), 9 (Data Protection) and 10 (Exclusion of Liability and Indemnity) of the CCRP Rules.

SECTION 4: CHECKLIST ON COMPLIANCE DOCUMENTATION *(Please attach necessary documents where applicable with this form)*

CATEGORY	LIST OF DOCUMENTATION
Medical Practitioner, Healthcare Institution, IP Insurer	Supporting Documents to show 3-incident trend threshold and attempts at resolving those disputes with Respondent: ➢ The first two incidents have to be within 5 years; ➢ The 3rd incident (rejected by Respondent; current case) has to be within 6 months from IP insurer's final reply; ➢ The five-year timeframe is calculated from the date of the Claim Advice (Claim Settlement Letter/Claim Rejection Letter).
IP Policy Holder	Supporting Document(s) to show past attempt(s) at resolving dispute with Respondent

END OF FORM