Reimbursement Claim Form [Patient]

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| **1** | **ADMINISTRATIVE SECTION** | |  | | |
| Policy Number: | | | Membership Number: | | |
| Patient Name: | | | Provider Name: | | |
| Date of treatment: | | | Patient Gender: | | |
| Mobile Number: | | | Email Address: | | |
| **2** | **MEDICAL SECTION** | | | | |
| Type of visit: □ Outpatient □ Inpatient □ Emergency □ Maternity □ Dental □ Optical | | | | | |
| If Pregnant: L.M.P. Date: | | | | Nature of Conception: | |
| Chief complaint: | | | | | |
| History of present illness (please include duration, date of onset, and when the patient became aware of each condition) | | | | | |
| Clinical findings/other conditions | | | | | |
| Past medical history | | | | | |
| Details of trauma - if applicable (when, where & how)  □ Work related □ RTA related (include a police report) □ Sports related | | | | | If yes:  □ Professional  □ Non-Professional |
| Diagnosis | | | | | |
| Treatment plan, recommended medications, investigations, and/or procedures | | | | | |
| **PATIENT DECLARATION MEDICAL PRACTITIONER DECLARATION** | | | | | |
| I hereby confirm that I am the patient/[CN]card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to [CN] Insurance© representative or any a [CN] company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to [CN] Insurance© representative or any of [CN] company affiliates to audit review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original. | | | | I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct. | |
| Name | Signature |
| Date |
| Stamp | |
| Signature | | Date | |

**WARNING**: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits/cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary. Claims must be submitted along with supporting documents within 30 days from date of service.

Send this claim form together with supporting material to Medical Department [Address here]