



# Medical Claim Reimbursement Form

## ATTENDING PHYSICIAN SECTION (\*Mandatory Fields)

To be filled by attending physician

Patient's Full Name  Date of Birth

Chief Complains\*

Diagnosis\*

How long has the patient been suffering from this sickness?\*

Please specify the date symptoms first appeared.

If treated by other medical provider please specify the name and treatment details

If the claim is resulting from pregnancy / childbirth, please provide the LMP\*

Details of the treatment (other than Prescription)

If further treatment or operative procedure anticipated, please provide the details

Physician's Name, Address and Tel. No.

Physician's Signature and Stamp

## CHECKLIST FOR INSURED MEMBER

REQUIRED	CHECK BOX	DOCUMENTS	NOTES
YES	<input type="checkbox"/>	Claim Form (including Attending Physician Section)	Fully completed and signed by you and your physician / surgeon
YES	<input type="checkbox"/>	Detailed medical report	Detailing ailment / diagnosis or accident with dates it started / happened, signed by your treating physician
YES	<input type="checkbox"/>	Original hospital / clinic bill	Original
If applicable	<input type="checkbox"/>	Copy of all relevant X-Rays / Echography / MRIs and reports	Should reflect your name and date they were taken
If applicable	<input type="checkbox"/>	Copy of all lab tests and reports	Only related to this incident
If applicable	<input type="checkbox"/>	Copy of police report	Required if claim relates to an accident

### Please remember:

To help us process your insurance claim as quickly as possible, we ask you to provide the above documents. Otherwise your claim could be delayed or potentially rejected.

## HOW TO SUBMIT THE CLAIM

Login to e-Services **OR** Please contact your H.R. for the Claim Submission Process