Better. Simple. Life.

# CLAIM FORM
# (Out-Patient)

Practitioners Name _____ Practitioners Official Stamp

_____

Postal Address _____

_____

Tel _____ Mobile _____

Fax _____

## PATIENT'S PARTICULARS

Full Name of Patient _____ Date of Birth _____

Full Name of Member (if patient is a dependant) _____

Policy No. _____ Member No. _____

Member's Employer Name _____ Dept/Branch _____

_____

1) Have you suffered from this sickness in the past? YES ☐ NO ☐

If YES, when did it start and how frequent is it? _____

## CONSULTATION/REFERRALS

**DIAGNOSIS:**

TREATMENT PRESCRIBED

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MEDICINES: | Prescription ☐ | Injection given ☐ | Dispensed ☐ | None ☐ |
| RADIOLOGY: | X-Ray ☐ | MRI/Cat Scan ☐ | Other ☐ | Other ☐ |
| PATHOLOGY: | Haemotology ☐ | Microbiology ☐ | Biochemistry ☐ | Histology ☐ |

| HOSPITAL NAME: | CONSULTANT REFERRED TO: | SPECIALITY: |
|---|---|---|
| | | |

## MEDICATION PRESCRIBED

_____

_____

Dr's Signature _____ Date _____

## DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature _____ Date _____

**UAP Insurance Company Limited**
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