

Medical Claim for Treatments and Referrals

IMPORTANT NOTE

1. Claim Form to be completed by the attending doctor
2. Attach original invoices, receipts and copies of prescriptions to the claim form
3. Medication/drugs bought over-the-counter will not be re-imbursed by the Scheme

PATIENT'S PARTICULARS

Surname _____ First Name _____ Age _____ Member No. _____

Employer _____

Name of Member (if Patient is a dependant) _____ ID/Passport No. _____

CONSULTATION/REFERRALS TO SPECIALISTS AND HOSPITAL ADMISSIONS

(to be completed by the consulting Doctors only)

Investigation/Procedure

	Cost (Kshs)
Procedure	
Radiology	
Pathology	
Others	

Referrals

Hospital Name	Consultant Referred to:	Speciality
	Full Name _____	
	Address _____	

Doctors Full Name _____ SS Number

Address of Practice _____ Code (s)

Nature of Illness/Diagnosis(es) _____

Do you consider this disease/condition/injury to be of an occupational nature YES NO

If yes, please state what you consider to be the cause (etiology) _____

SCRIPT FOR MEDICINES PRESCRIBED BY PRACTITIONER

	Amount (Kshs)
Consultation Fee	
Medication Prescribed	

Dr's Signature _____ Date & Stamp _____

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 you communicating with my medical doctor and Health Insurance Scheme with regard to this claim

Member's Signature _____ Date _____

Original – Attach Invoice, Duplicate – Investigations, Triplicate – Pharmacy, Quadruplicate – Primary Providers copy