MEDICAL - CLAIM FORM

This form should be completed in BLOCK LETTERS, signed by the member and the doctor on whose recommendation the treatment was undertaken, and returned to us with all relative accounts or vouchers supporting these expenses attached.

PART I (Member to fill)

Name of Employer .....

Member's name.....Telephone No.....

Patient's name .....Membership No.....

Relationship to member.....Age:.....

Are you a member of the National Hospital Insurance Fund?.....

Are you insured under any other insurance scheme?.....

PART II (Doctor to fill)

Nature or Condition which necessitated treatment:.....

.....

Date when patient was first medically examined for this condition.....

Has the patient suffered from this complaint previously, if so when.....

Nature of treatment & drugs prescribed.....

.....

ITEMS	AMOUNTS
Consultation/Doctor's fees	
Prescribed Medicine/Drugs/Injection	
Lab, X-ray/Diagnostic Services	
Treatment and surgical appliances	
Others (please specify)	
TOTAL CLAIM AMOUNT	

The above-mentioned patient has undertaken the treatment specified on my recommendation:

Name of Doctor:.....Signature of the Doctor:.....

Qualification of Doctor:.....Telephone No.....

Doctors Postal Address .....

I ..... declare that all the statements given by me on this form are to the best of my knowledge true and complete. I authorize the Insurance Company to obtain medical information from the doctor I have consulted and shall submit to any medical examination(s) if so required by the Company.

Patient Signature..... ID No. .....

Telephone No .....Date .....

GA Insurance Limited
P.O. BOX 42166-00100, NAIROBI
Telephone 2711633; Fax 2714542; Office Mobile: 0736 711633, 0721 677273
Health Division Emergency Lines: 0710 607333, 0737 711633, 020-3535308
E-mail. health@gakenya.com