MEDICAL CLAIM FORM

Name of Hospital/Provider: …… Tel & Fax No……

Name of Employer: ……..…….. ….

Policy / Membership No. …….

Employee's Name: ……. Staff No. (If available) ……

Patient's Name: ……..…….... Date of Birth/Age: ……

Relationship to Employee: …… I. D. No……

I …….. do hereby authorize any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and / or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident, any treatment, examination, advice or hospitalization. I have also been advised by APA INSURANCE LTD and have understood the various exclusions. Any photocopy of this authorization shall be taken as the original copy.

Signature of Member…….. Date……

TO BE FILLED BY DOCTOR

Final Diagnosis of illness Treated: ……..……...

When was the condition first diagnosed: …….

SICKNESS

Cause of illness/es:…….…….

Is the condition a General Exclusion: Yes/No

Nature of treatment and given recommendations:…….……

…….

ACCIDENTS

i. **Date of Accident: …… Cause of Accident:…….……**

ii. **Nature of injuries:……..……..**

Kshs

Private Doctors Fees…….=

Prescribed Drugs……..=

Specialists and Pathologists Fees, X-ray & Physiotherapy fees……=

Total Claim……....=

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: …… Doctor's Signature & Stamp: …….……..