CLAIMS FORM

DATE ____________ **TIME OF ATTENDANCE** ____________

DDMMYYYY

HOSPITAL NAME ____________ **STATE** ____________

ENROLLEE DETAILS

ENROLLEE NAME ____________ **GENDER** ____________

FIRST LAST NAME

PLAN NAME ____________ **DOB** ____________

DDMMYYYY

COMPANY NAME ____________

AUTHORIZATION CODE ____________ ENROLLEE SIGNATURE

SERVICE DETAILS

TYPE: OPD/ADM ______ **REFERAL** ______ **DISCHARGE DATE** ______

DDMMYYYY

SIG.HISTORY ____________

P/E FINDINGS ____________

INVESTIGATIONS ______ **IF YES, STATE** ____________

Y/N

DIAGNOSIS ____________ **DGX CODE** ____________

ICD FORMAT

TREATMENT	TXT CODE (ICD FORMAT)	COST
	TOTAL COST	

DECLARATION:I declare that the services detailed on this form were medically necessary and the particulars as stated above are true in every respect.

SIGNATURE ____________ **DATE** ____________

ATTENDING DOCTOR

HOSPITAL STAMP

KINDLY ATTACH ALL INVESTIGATION RESULTS AND REPORTS,
MEDICAL REPORTS REQUIRED FOR ALL ADMISSIONS,PROCEDURES AND SURGERIES.