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ALFALAH INSURANCE COMPANY

MEDICAL INSURANCE CLAIM FORM (REIMBURSEMENT ONLY)

TO BE FILLED BY THE EMPLOYEE (Incomplete form will not be acceptable) DATE: _____

PATIENT'S INFORMATION::	**NAME:** _____ **AGE:** _____ **RELATION WITH EMP:** _____ **CNIC #:** _____
EMPLOYEE'S INFORMATION:	***NAME:*** _____ ***EMPLOYEE ID # :*** _____ ***OFFICIAL EMAIL:*** _____ ***CONTACT / MOB. #:*** _____ ***PERSONAL EMAIL:*** _____ ***OFFICE LANDLINE PH#:*** _____
BANK ACCOUNT DETAIL:	**ACCOUNT TITLE :** _____ **ACCOUNT # :** _____
EMPLOYER'S INFORMATION:	**CO. NAME** _____ **POLICY #:** _____

DETAIL OF MEDICAL EXPENSES **Hospital Bill NO.----------**

SR No	DESCRIPTION	(for Claimant's use only) CLAIMED AMOUNT (RS)	(For AFI Co. use only) APPROVED AMOUNT (RS)	
1	ROOM CHARGES PER DAY_____ * NO OF DAYS____			
2	MEDICINES			
3	INVESTIGATIONS (LAB + RADIOLOGY ETC)			
4	CONSULTATION			
5	OPERATION FEE			
6	ANAESTHESIA FEE			
7	O.T (OPERATION THEATRE) / LABOUR ROOM CHARGES			
8	PRE HOSPITALIZAITON CHARGES			
9	POST HOSPITALIZAITON CHARGES			
10	PACKAGE / OTHER (Please specify nature of other charges)			
Gross Total				
Less deductible/over the limit/Non-medical items/others if any.				
TOTAL CLAIMED AMOUNT				

MEDICAL CERTIFICATE

TO BE FILLED BY TREATING DOCTOR (Claim will not be processed for payment with out filling the Medical Certificate)

PATIENT'S NAME : _____ AGE: _____	HOSPITAL REFERENCE NO (PATIENT'S FILE #): _____
DATE OF ADMISSION:_____	DATE OF DISCHARGE: _____
DATES OF ILLNESS / ACCIDENT / INVESTIGATION / TREATMENT	_____ _____
FULL PARTICULARS OF THE ILLNESS /REASON OF HOSPITALIZATION	_____ _____
DID THE PATIENT SUFFER FROM THIS ILLNESS BEFORE? IF YES, FOR HOW LONG?	_____ _____
NAME ,ADDRESS AND TELEPHONE # OF THE HOSPITAL IN WHICH HE/SHE HAS BEEN TREATED	_____ _____
NAME & ADDRESS AND TELEPHONE # OF THE ATTENDING M.P / CONSULTANT / SURGEON	_____ _____
SIGNATURES & STAMP OF ATTENDING DOCTOR WITH PMDC REGESTRATION NO.	_____ _____

CHECK LIST

In support of the above claim, I am enclosing the following documents (*Please indicate by tick mark)*

MANDATORY DOCUMENTS NEED TO BE ATTACHED	Yes	No	If "NO" Then Describe the Reason
1. Final Hospital Bill with Receipts (Original)			
2. Discharge summary indicating final diagnosis			
3. Original cash memos of medicines from the hospitals/chemist supported with proper doctor's prescriptions			
4. Receipt (Original) and pathological/radiological test reports with proper prescription of the attending medical practitioner/ Consultant and Surgeon.			
5. Surgeon certificate stating nature of operation performed and surgeon's bill and receipt (if applicable).			
6. Attending doctor's / Consultant's / anesthetist's original bill & receipt (If applicable).			
7. Copy of Computerized Birth Certificate (In Case of Delivery / Child Birth)			
8. Copy of Company's Prior Approval (in non-emergency cases)			
9. Copy of CNIC of patient (if patient is adult) & Copy of Health Card issued by Insurance Company.			

SPECIAL INFORMATION ABOUT THE CLAIM

PARTICULARS	CLAIMANT'S REMARKS	HR'S RECOMMENDATIONS
• Reason for Cash Treatment in Panel Hospital		
• Reason for treatment in Non-Panel Hospital.		
• Reason for late submission of the claim		

DECLARATION

I hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form is true, correct and complete.
(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
(c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover hereunder in respect of any or all claims, past, present or future.
(d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
(e) I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme of insurance. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

Employee's Signature **Employer's Signature & Stamp**