Alfalah Insurance

OPD CLAIM FORM (TO BE FILLED BY EMPLOYEE)

1	NAME OF THE POLICY HOLDER					
2	BRANCH & CITY					
3	NAME OF EMPLOYEE					
4	EMPLOYEE#		PLAN			
5	EMAIL ID		CONTACT NO.			
6	NAME OF PATIENT		AGE (In Years)			
7	RELATION WITH EMPLOYEE (encircle the right choice)		SELF	SPOUSE	DAUGHTER	SON
8	DIAGNOSIS					
9	TREATMENT DATES / MONTH					

	DETAILS OF AMOUNT CLAIMED	
	DATE / TREATMENT DETAIL / INVOICE #	**AMOUNT IN RS.**
(i)		
(ii)		
(iii)		
	TOTAL AMOUNT CLAIMED	

CHECKLIST:

- Please submitt monthly OPD bills with a single Claim Form for a single patient.
- Use separate Claim Forms if bills are for more than one patients / persons.
- Please ensure to attach the following documents along with this claim form. **(***Please indicate by tick mark* ***yourself)***

Sr#	DOCUMENTS	YES	NO	If "NO" Then Describe the Reason
(i)	Copy of the Prescription of the doctor			
(ii)	Original Invoices of the doctor & lab etc			
(iii)	Original Pharmacy Invoices			
(iv)	Copy of Reports of the investigations claimed			
(v)	Copy of CNIC and Health Card			

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim.

_____ Employee's Signature with date

_____ HRD – Bank Alfalah Limited

FOR COMPANY'S USE ONLY:

CLAIM DUE TO	**CONSULTATION**	**PHARMACY**	**INVESTIGATIONS**	**DENTAL**	**OTHER (SPECIFY)**
	Rs.	Rs.	Rs.	Rs.	Rs.

Any Deduction	Rs.	**Amount Approved**	**Rs.**
Remarks / Reason of Deduction		Final Diagnosis	
Claim Processed By:		Claim Approved By:	

Head Office: 5-Saint Mary Park, Gulberg III, Lahore-Pakistan
UAN: +9242-111-786-234 Fax: +9242-35774329, 35774330
Email: health@alfalahinsurance.com