ALFALAH INSURANCE COMPANY

FAX INTIMATION FORM

FROM (HOSPITAL NAME):	To : ALFALAH INSURANCE HEALTH DEPARTMENT
Email: Phone No:	UAN : 111-786-234 HOTLINE NUMBER: 0321-4041555, 0322-4041555 Email: health@alfalahinsurance.com
FAX NUMBER:	FAX NUMBER: 042-35774329/35774330
HOSPITAL REFERENCE NO: (PATIENT'S FILE #)	INTIMATION DATE:

PATIENT NAME	________________ AGE: ________________ Relation with employee : ____________ NIC # ________________
POLICY HOLDER	Company : ______________ Employee Name: ______________ HEALTH CARD ID # : ____________
DATE / TIME OF ADMISSION	DATE : TIME: AM/PM ROOM / ICU NO #: __________
REASON FOR ADMISSION (presenting complaints)	CONSULTANT NAME: __________
PROVISIONAL DIAGNOSIS	
INTENDED LINE OF TREATMENT	
WILL ANY OF THE PROCEDURES MENTIONED BE CARRIED OUT? IF SO PLEASE PROVIDE BRIEF DETAILS AND REASONS	SURGERY : MRI : CT SCAN : BLOOD TESTS : ANY OTHE :
ROOM CHARGES PER DAY	RS. ____________ EXPECTED LENGTH OF STAY __________
ESTIMATED BILL (RS.)	

Signed for and on behalf of:

Patient/Guardian……………………………………..

Left Thumb Impression of the patient………………………

Signed for and on behalf of Hospital

Signature…………………..............

Name……………………………………

INSTRUCTIONS FROM ALFALAH INSURANCE COMPANY LTD

ALFALAH INSURANCE CLAIM NO………………………...

DATE	APPROVED LIMIT	REMARKS	SIGNATURE

Imp Note: Patient staying in room higher than their entitlement will be responsible for payment of additional expenses for room rate plus any increase in other expenses as well.