CLAIMS FORM

DATE		**TIME OF ATTENDANCE**	
	DDMMYYYY		
HOSPITAL NAME		**STATE**	

ENROLLEE DETAILS

ENROLLEE NAME		**GENDER**	
	FIRST LAST NAME		
PLAN NAME		**DOB**	
ENROLLEE NUMBER			DDMMYYYY
COMPANY NAME			
AUTHORIZATION CODE		ENROLLEE SIGNATURE	

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.