

**OLD MUTUAL****OUT-PATIENT  
CLAIM FORM****OLD MUTUAL GENERAL INSURANCE KENYA LIMITED**

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**PLEASE COMPLETE THIS FORM AND ANSWER ALL QUESTIONS.**

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Practitioners Name JEDIDAH BROOKEPostal Address NAIROBI, KENYATel No. \_\_\_\_\_ Mobile +254 708 42260

Email \_\_\_\_\_

**PATIENT'S PARTICULARS**Full Name of Patient ADRIEL URI GWETH Date of Birth 12/08/2019Full Name of Member (if patient is a dependant) JANET ATIENORelationship of patient to principal member: (tick one box) Spouse ☐ Child ☒ Self ☐ ID. No. \_\_\_\_\_Member No. 9069-03 Member's Tel No. \_\_\_\_\_Member's Employer Name DI DOBIE AND COMPANY LIMITED Dept./Branch \_\_\_\_\_Have you suffered from this sickness in the past? YES ☐ NO ☒

If YES, when did it start and how frequent is it? \_\_\_\_\_

**CONSULTATION/REFERRALS**DIAGNOSIS: SPEECH DELAYTREATMENT PRESCRIBED SPEECH THERAPY

MEDICINES:	Prescription	Injection given	Dispensed	None
RADIOLOGY:	X-Ray	CT Scan	Ultrasound	Other
PATHOLOGY:	Haematology	Microbiology	Biochemistry	Histology

Hospital Name: MP SHAH Consultant Referred To: Dr. BROOKE Specialty: MEDICAL SLP**MEDICATION PRESCRIBED:**Dr's Signature J.BDate 16/05/2024**DECLARATION**

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor / medical service provider with regard to this claim.

Member's /Parent's /Guardian's Signature (if patient is below 18) JANET. A. Date 16/05/2024