OLDMUTUAL

OUT-PATIENT CLAIM FORM

OLD MUTUAL GENERAL INSURANCE KENYA LIMITED
Old Mutual Tower, Upper Hill Road, PO Box 43013 - 00100, Nairobi, Kenya
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PLEASE COMPLETE THIS FORM AND ANSWER ALL QUESTIONS.

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Practitioners Name JEDIDAH BROOKE

Postal Address NAIROBI, KENYA.

Tel No. _____ Mobile +254708422260

Email _____

Practitioner's Official Stamp

SOCIAL SERVICE LEAGUE
M.P. Shah Hospital
BILLING DEPT
PAEDITRIC SPECIALITY CLINIC
P.O. BOX 14497 - 00800 NAIROBI

PATIENT'S PARTICULARS

Full Name of Patient KYLIAN KELANI GAYAH Date of Birth 21/05/2021.

Full Name of Member (if patient is a dependant) KENNEDY GAYAH

Relationship of patient to principal member: (tick one box) Spouse (Child) Self ID. No. _____

Member No. 3247219-01. Member's Tel No. _____

Member's Employer Name BIERSDORF EAST AFRICA. 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 DELAY

TREATMENT PRESCRIBED SPEECH THERAPY

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

Hospital Name: MPSHAH Consultant Referred To: Dr. BROOKE Specialty: MEDICAL SLP

MEDICATION PRESCRIBED:

_____

_____

_____

Dr's Signature J.B **Date** 18/05/2024

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) KENNEDY G. **Date** 18/05/2024.