Eden Care Medical Health Insurance Claims Form

EDEN CARE

1. Patient Details

Membership number

Surname

First name(s) (as per identity document)

Date of birth D D - M M - Y Y Y Y

Gender M F

Cellphone

Email

2. Medical Practitioner Details

Name

Specialization

RMDC Reg No

3. Treatment Details

Treatment date D D - M M - Y Y Y Y

Referring Doctor

Healthcare Facility

Referred To (if applicable)

Final Diagnosis ICD Code

Final Diagnosis Description

Additional Supporting or Underlying Diagnoses

Pre-Authorisation Number (If applicable)

Type of Care Outpatient Optical Maternity Inpatient Dental

4. Services / Items Claimed (Can be left blank if submitted with an itemised Invoice)

Item	RMPC Procedure Code	Procedure	Total Billed	Co-pay Amount	Total Claimed
1					
2					
3					
4					
5					
6					

Patients Signature

Date D D - M M - Y Y Y Y

Doctors Signature

Date D D - M M - Y Y Y Y