

PATIENT IM FORM

pet 24/07/2021

Practitioner Official Stamp

SINAI HOSPITAL RONGAI

Head Office: Silver Plaza Magadi Road next to Tosha Petrol Station, Rongai

Tel: 0759 875 100 / 0726 806 412

P.O. Box 36653 - 00200 Nairobi

Birth 07/03/1996

Email: sinaihosp@gmail.com www.sinaihosp.co.ke

PATIENT'S PARTICULARS

Name: Judy Mwangi Njugu

Member (if patient is a dependant)

INVOICE - OUTPATIENT

CUSTOMER: UAP INSURANCE

Invoice No: SNV00137002

ADDRESS: 12589 PHONE: 0285279

Invoice Date: 24/07/2021

CLIS REF: UPO17-00

d/o JUDY MWANGI

DESCRIPTION

PHARMACY-TRICKIT- 24/07/2021

QTY	PRICE	DISC%	VAT%	TOTAL COST
1	850.00	0.00	0.00	850.00
SUB TOTAL:				850.00
VAT TOTAL:				0.00
LESS WHIF				0.00
TOTAL:				850.00

Prepared By: MAKENA C

Admission Date:

24 JUL 2021

Discharge Date:

PRESCRIBED

Prescription

Injection given

MHIF No:

Claim No:

Dispo

None

LESS WHIF

X-Ray

Name:

Judy

MRI/Cat Scan

Other

Other

Haeematology

Microbiology

Biochemistry

Histology

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Consultant Clinician by: Corebase Solutions Ltd

PRESCRIBED:



Signature: [Handwritten Signature]

I have not withheld or misstated material information relating to this claim and have no intention of communicating with my medical doctor with regard to this claim.

Signature

Date: 24/07/21

UAP Insurance Company Limited
AP Old Market Tower, Upperhill Road P.O. Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000

Email: neam@uap-group.com Website: www.uapoldmutual.com

ISO 9001 Certified | A Member of the Association of Kenya Insurers (AKI)

Regulated by the Insurance Regulatory Authority

OUT-PATIENT CLAIM FORM

Practitioner's Name Sinai Hospital Rongai
Postal Address 36653 - W 200 RD
Tel No. 0759 875 100 Mobile _____
Email Sinaihospital@gmail.com

Practitioner's Official Stamp

PATIENT'S PARTICULARS

Full Name of Patient Judy Wanjiru Njuguna Date of Birth 09/03/1996
Full Name of Member (if patient is a dependant) Judy W. Njuguna
Member's Tel No. 0712465531 Member No. UPO1700
Member's Employer Name UPFIELD 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:

UTI

TREATMENT PRESCRIBED

MEDICINES: Prescription ☐ Injection given ☐ Dispensed ☐ None ☐
RADIOLOGY: X-Ray ☐ MRI/Cat Scan ☐ Other ☐ Other ☐
PATHOLOGY: Haematology ☐ Microbiology ☐ Biochemistry ☐ Histology ☐



Hospital Name: _____ Consultant Referred To: _____ Specialty: _____

MEDICATION PRESCRIBED:

Dr's Signature [Signature]

Date 24/07/21

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 with regard to this claim.

Member's Signature [Signature]

Date 24/07/21

UAP Insurance Company Limited

UAP Old Mutual Tower, Upperhill Road. P.O Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000
Email: health@uap-group.com Website: www.uapoldmutual.com