UAP OLDMUTUAL

OUT-PATIENT CLAIM FORM

Practitioners Name PENDA HEALTH

Postal Address _____

Tel No. _____ Mobile _____

Email _____

Practitioner's Official Stamp

PENDA HEALTH LIMITED
PIPELINE
23 AUG 2021
P.O. Box 22647-00100 NAIROBI

PATIENT'S PARTICULARS

Full Name of Patient Daniel Charles mavun Date of Birth 2/8/2017

Full Name of Member (if patient is a dependant) kepher mavum

Member's Tel No. 0725079814 Member No. UK0888810-03

Member's Employer Name KNEC 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: Acute Hypopharyngitis

TREATMENT PRESCRIBED

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

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

MEDICATION PRESCRIBED:

Antihistamine, Antibiotic, Antipyretic.

Dr's Signature _____ **Date** 23/8/2021

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 _____ **Date** 23/08/2021

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