UAP OLDMUTUAL

OUT-PATIENT CLAIM FORM

Practitioners Name ____________________

Practitioner's Official Stamp

Postal Address ____________________

Tel No. ____________ Mobile ____________

Email ____________________

PATIENT'S PARTICULARS

Full Name of Patient ABIGAIL MUNGAI KIOKO Date of Birth 2017

Full Name of Member (if patient is a dependant) URBANUS KIOKO MWANIA

Member's Tel No. 0724 854483 Member No. 02-15151904

Member's Employer Name FAULU MICRO-FINANCE Dept. /Branch MOI-AVENUE

Have you suffered from this sickness in the past? YES NO ✓

If YES, when did it start and how frequent is it? N/A

CONSULTATION/REFERRALS

DIAGNOSIS: URTI - flu + cough; fever

TREATMENT PRESCRIBED

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

JOCHAM HOSPITAL Mob: 0723 207 664 0733 710 174 Wireless: 020 8017612 Fax: 020 2046359 P.O. Box 88984, MOMBASA

Hospital Name: ____________ Consultant Referred To: ____________ Specialty: ____________

MEDICATION PRESCRIBED:

① Antibiotics
② Analgesics

Dr's Signature Dr. Shaban **Date** 20/06/24

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** 20/6/21

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: uapoutpatient@uapoldmutual.com Website: www.uapoldmutual.com

JOCHAM HOSPITAL

AT JUNCTION OF NEW AND OLD MALINDI RD-KENGELENI
P. O BOX 88984 MOMBASA
TEL Nos. :474472/4,0208017612,0722207664
Email :info@jochamhospital.org

FINAL INVOICE

Patient 00098958
ABIGAIL MUNGAI KIOKO
P.O. Box -
0712781932

MCC No.:
Policy No. :
Paying by :
Payer Account:D0089
UAP INSURANCE COMPANY LTD
P.O. Box 43013 - 0100-NAIROBI

Inv. Date....: 20/06/2021
Inv. No. .....: S210601883
Staff Ref. ...: 02151519
Next of Kin KAMENE IRENE
Age.....: 4
Disease Codes:

Attending Doctor(s):-
A/c. Name

Credit/Smart Ref S210601883

Date	Description of Services	Ref.	Amount	Balance
20/06/2021	CONSULTATION	S210601883	800.00	800.00
20/06/2021	LABORATORY	2106000876	1,320.00	2,120.00
20/06/2021	PHA-S00272-PHARMACY	P210603120	402.00	2,522.00
20/06/2021	PHA-S00034-PHARMACY	P210603120	267.00	2,789.00
20/06/2021	PHA-S00037-PHARMACY	P210603120	173.00	2,962.00
20/06/2021	PRESCRIPTION FEE	P210603120	50.00	3,012.00
			Invoice Amount	3,012.00

JOCHAM HOSPITAL
Mob: 0722 207 664
0733 710 174
Wireless: 020 8017612
Fax: 020 2040359
P.O. Box 88984, MOMBASA

E&OE

Name.....:_____

Signature:_____ Date.....:20/06/2021

JOCHAM HOSPITAL

P. O. Box P. O BOX 88984 MOMBASA
Tel. 474472/4,0208017612,0722207664
info@jochamhospital.org

CONSULTATION DEBIT

Patient:-
No. ..:00098958
Name..:ABIGAIL MUNGAI KIOKO
Account:-
No. ..:D0089
Name..:UAP INSURANCE COMPANY LTD

Credit Slip No.:S210601883
Date.....:20/06/2021

Ref. No. :S210601883

CONS	CONSULTATION	800.00

Total Due....:	800.00
Paid.....:	0.00
Net Due.....:	800.00

I confirm that I have received the above services.

Name.....: IRENE KIAMENE

Signature: _____ Date.....:20/06/2021

Processed By: MAWEU

Outpatients

JOCHAM HOSPITAL
Mob: 0722 207 664
0733 710 174
Wireless: 020 8017612
Fax: 020 2040359
P.O. Box 88984, MOMBASA

JOCHAM HOSPITAL

P. O. Box P. O BOX 88984 MOMBASA
Tel. 474472/4,0208017612,0722207664
info@jochamhospital.org

P H A R M A C Y D E B I T

Patient:-
No. ..:00098958 Name..:ABIGAIL MUNGAI KIOKO
Account:-
No. ..:D0089 Name..:UAP INSURANCE COMPANY LTD
Location :PHA Name..:PHARMACY

Credit Slip No.:S210601883
Date.....:20/06/2021
Ref. No. .....:P210603120

Item Code	Description	Qty	Selling Price	Total
S00272	SYR CLAVAM BD 228.5MG(AMOXICLA	1	402.00	402.00
S00034	CEZINE 60ML -CETRIZINE	1	267.00	267.00
S00037	DELASED PAEDS 100ML(COUGH SYR	1	173.00	173.00
	Prescription Fee:	50.00		

Total Due....: 892.00
Paid.....: 0.00
Net Due.....: 892.00

I confirm that I have received the above services.

Name.....: IRENE KAMENE

Signature: _____ Date.....:20/06/2021

Processed By: REBECCA Pharmacy

JOCHAM HOSPITAL
Mob: 0722 207 664
0733 710 174
Wireless: 020 8017612
Fax: 020 2040359
P.O. Box 88984, MOMBASA

P A T H O L O G Y D E B I T

Patient:-
No. ..: 00098958 Name..ABIGAIL MUNGAI KIOKO
Account:-
No. ..: D0089 Name..UAP INSURANCE COMPANY LTD

Credit Slip No.: S210601883 Ref. No. 2106000876
Date.....: 20/06/2021

LB0081	FULL HAEMOGRAM	1	1,320.00
		Total Due....:	1,320.00
		Paid.....:	0.00
		Net Due.....:	1,320.00

I confirm that I have received the above services.

Name.....: IRENE KAMENE

Signature:

Date.....: 20/06/2021

Processed By: MKALA Pathology

JOCHAM HOSPITAL
Mob: 0722 207 664
0733 710 174
Wireless: 020 8017612
Fax: 020 2040359
P.O. Box 88984, MOMBASA

Smart
Secure, Fast, Access

SMART BILLING UTILITY REPORT

Service Provider: JOCHAM HOSPITAL
Account Name: UAP INSURANCE COMPANY LTD
Satellite Clinic JOCHAM HOSPITAL
Provider Number: SKSP_116
Date Selected: 20-Jun-2021 TO 20-Jun-2021

No.	Billing Date	Account Name	Scheme Name	Benefit Description	Member Number	Patient Name	Patient File No	Invoice No	Claim Type	Amount
1	20/06/2021 10:57:43	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00098958	S210601883	NORMAL CLAIM	800.00
2	20/06/2021 11:26:43	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00098958	S210601883	NORMAL CLAIM	1,320.00
3	20/06/2021 12:17:16	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00098958	S210601883	NORMAL CLAIM	892.00
										Grand Total: KShs 3,012.00

MEDICAL SERVICE PROVIDER:		**PAYER/SCHEME ADMINISTRATOR:**	
SENT BY:		**APPROVED BY:**	
SIGNATURE/STAMP:		**DESIGNATION:**	
DATE:		**DATE:**