Adamjee Insurance Company Limited

2nd Floor, Adamjee Insurance Building, Opp: National Bank of Pakistan. I. I. Chundrigar Road. Karachi-74000
Telephones: (021) 32414028; 32420740; 32423812 Fax (021) 32470111
Email: health@adamjeeinsurance.com

HEALTH INSURANCE – IN-PATIENT CLAIM FORM

INSTRUCTIONS: (please read them carefully)

1. In order for us to provide you with the efficient service; please complete the form accurately in **"CAPITAL LETTERS"**. (Photocopies can also be used).
2. Filled forms should be sent to Adamjee Insurance Company Limited within 30 days of the expense incurred date.
3. Please attach the following documents with the form for the fast processing of your claim.

I- Proper hospital bill in original with type of accommodation used (room type) and breakup of total bill according to:
(a) Room charges **(b)** Lab tests and Radiology charges **(c)** Consultation charges **(d)** Anesthesia charges (if any)
(e) Surgeon fee with details if any) **(f)** Operation Theatre charges (if any) **(g)** Medicines (used during hospitalization
(h) Other miscellaneous medical expenses like oxygen & blood, etc

II- Laboratory or Radiology reports along with doctor's advice.
III- Proper itemized bill(s) and payment receipt(s) of the hospitalization.
IV- Proper itemized bill of the medicines purchased supported by the physician's prescription.
V- Hospital discharge/clinical summary (in case of hospitalization).
VI- Copy of birth certificate(s) in case of child birth.

To be completed by Employee:

☐ Hospitalization Claim ☐ Pre & Post Hospitalization Claim

Name of the Company: _____ Policy #: _____

Name of Employee: _____ Credit Letter #: _____

Name of the Patient: _____ Catch Card #: _____

Relationship with Employee: _____ Date of Birth: _____

CNIC # of employee: _____ Claimed Amount: _____

DETAILS OF ILLNESS:

Date of illness first noticed: _____ Nature Of Illness: _____

Has the claimant suffered from this illness before: **YES** ◯ **NO** ◯

If yes, than please provide date(s) and details: _____

DETAILS OF HOSPITALIZATION:

Name of Hospital attended: _____

Name of treating physician: _____

Date of Admission: _____ Date of Discharge: _____

Emergency treatment or Elective: _____

Is the patient entitled to any other benefit or compensation from any other source? If so name the name of companies or other source, and give amount of benefit payable by each: If yes, please give details:

DECLARATION:

I hereby certify that all answers, and all documents submitted with claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any company, institution or any other person who has any record or information about me and/or of my family members to provide Adamjee Insurance Company Limited with the information, including copies of their records with reference to any sickness or accidents, any treatment, examination, advice or hospitalization. Any photocopy of this declaration shall be taken as the original copy.

Signature of the Patient **Signature & Seal of the Employer** **Date**

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To be completed by Attending Physician/ Hospital:

Patient's Name: _____

Final Diagnosis: _____ Procedure: _____

Are you the patient's primary physician: **Yes** ◯ **No** ◯

When the patient did first consult you for this complain? **Day**: _____ **Month**: _____ **Year**: _____

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief:

Signature & Stamp of the Attending Physician: _____

Name & Address: _____

Phone Number: _____ Fax #: _____

Mobile #: _____ Date: _____

NOTE:
For speedy settlement of the claim, we request you to please fill in each and every column with as much details as possible. Please do not leave any column blank.

FOR OFFICIAL USE ONLY

i. Is the person covered under the policy? Yes/No _____

ii. What is the insured maximum limit:
- Per ailment Rs. _____
- R/B-Limit Rs. _____
- PC-Limit (if concerned) Rs. _____

iii. Are the bills/prescriptions attached in order? Yes/No. _____

iv. Is the amount claimed within the limit Yes/No. _____

v. Amount claimed: _____

vi. Amount approved: _____

vii. Signature of approver: _____