

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Sex:    Male ☐ Female ☐

Policy Number \_\_\_\_\_

Age:

Provider Details

Name of Doctor: \_\_\_\_\_

Hospital/clinic Name: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

Id Number \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

TREATMENT DETAILS

Date of Service \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment given: \_\_\_\_\_

Treatment Code: \_\_\_\_\_

Referral Code: \_\_\_\_\_

Item Description	Duration	Rate	Amount(N)
Accommodation			
Feeding			
Consultation Fees			
Laboratory Investigation			
Drugs			
1			
2			
3			
4			
5			
6			
7			
TOTAL			

Please attach to this form a medical report containing details of treatment and copies of laboratory investigations result

ACKNOWLEDGMENT (To be filled by client only)

I confirm that I received the above treatment:

Name \_\_\_\_\_

Signature/Date: \_\_\_\_\_

OFFICE USE ONLY:

Date Received \_\_\_\_\_

Name & Signature of Staff. \_\_\_\_\_