Premium Health
Health Maintenance Organizations

CLAIMS FORM

Please complete and return to Premium health.
Please note that premium health does not undertake to pay in full all submitted bills as it reserves the right to vet all bells according to premium health tariff.

Date: .....

Provider name: ..... Provider Code .....

Enrollee name: ..... Enrollee I.D.no: ..... Enrollee Contact.no: .....

Authorization Code .....

Diagnosis .....

Admission Date: ..... Discharge Date: .....

Pls note that first 2 days of admission is covered under capitation

	Consultation	Cost
	Lab Tests	**Quantity**
	Radiological Investigations	**Quantity**
	Prescription	**Dosage**
	Accommodation	**No of Days**
	Feeding	**No of Days**
	Others	
	TOTAL	

Surgery done (please specify) _____

Types of Complementary treatment given e.g. Physiotherapy, other (please specify)

Declaration: I declare that to the best of my knowledge and belief, the above statement is true and complete

Medical officer's name _____ *Patient's name* _____

Medical officer's signature _____ *Patient's signature* _____

FOR OFFICIAL USE ONLY

Approved by _____ Amount approved _____

Signature & Date _____

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