Reimbursement Claim Form

Claim No.	:	1234	Authorization No.	:	122
Member Name/ Date of Birth	:	1996-06-20	Membership No	:	1234
Member Address/Tel	:	971506245967	Expiry date of policy	:	2023-12-20

Medical Section

Medical Practitioner's Name and Address/Tel.

Amirtha Patel

declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Signature & Stamp

Medical condition:

gfgh

Please Give the date on which your patient first consulted any doctor for this condition

Date

2024-04-25

History of medical condition:

Details of Physical findings

Details of any investigations done with relevant dates.

Details of treatments done with relevant dates.

Total Amount

345.0000

Diagnostic Procedures referred outside

gfgh

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Patient's Signature
2024-04-25

Date

Pharmaceuticals (to be filled by treating doctor only)