SHAHEEN INSURANCE COMPANY LIMITED
Joint Venture Of Shaheen Foundation-PAF, Hollard Insurance and FCSC
H.No.46,Khayaban-e-Suharwardy, Islamabad P.O Box No: 44000
UAN: (92-51)111-765-111 Fax.No: 92-51-2829515

IN-PATIENT DEPARTMENT EXPENSE CLAIM FORM

EMPLOYEE INFORMATION (To be filled in by the Employee in Capital Letters)

Date: _____

Policy Holder`s Name: COMSATS Institute of Information Technology M.A Jinnah Campus, Defence Road, Off Raiwind Road, Lahore.

Period Of Insurance: From 01-07-2012 **To** 30-06-2013 **Policy No:** 2012/06/114HHHDP00027

Name of Patient: _____ **Shaheen ID No:** _____

Name of Employee *(If Patient is dependent)*: _____ **Shaheen ID No:** _____

Relation with Employee *(If Patient is dependent)*: _____ **Sex(Tick One):** *1.Male* *2.Female*

Address of Employee: _____

Is any part of this claim recoverable under another insurance policy or third party YES ☐ ***NO*** ☐

If `Yes` then provide following details:

State whether (Tick whichever is applicable): ***1.*** *Another Insurance Policy* ***2.*** *Third Party*

Name of Insurer/Third Party: _____ *Policy No:* _____

Address of Insurer/Third Party: _____

I,the above named employee, declare that the information provided in this form is, to the best of my knowledge. I authorize Shaheen Insurance Company Limited(The Company) to settle this claim in accordance with the patient`s available benefit/entitlement under the terms of the Group Hospitalization Insurance. Furthermore, I agree that in case of discrepancy in documents is found then the company has right to refuse the said claim

Signature of Employee: _____

Designation: _____

EMPLOYER`s VERIFICATION (For Group Insurance Policy Holder`s)

We confirm that the patient in respect of whom benefits are claimed is an eligible insured, covered under our Group Hospitalization Insurance Policy, referred in `Employee Information` section above. Furthermore, we agree that in case of discrepancy in documents is found then the company has right to refuse the said claim. We authorize Shaheen Insurance Company Limited(The Company) to settle this claim in accordance with patient`s available benefits entitlements under the terms of the Group Hospitalization Insurance policy and pay the amount of settle claim to:

Payee`s Name: _____

Payee`s Full Address: _____

Date: _____

_____

Signature of Chief Executive with Stamp

TREATING DOCTOR`s REPORT (To be filled in by the Treating Doctor in Capital Letters)

Date: _____

Attending Doctor`s Name: _____ **Contact No:** _____

Name of Hospital *(where patient was treated)*: _____ **Contact No:** _____

Address of Hospital: _____

Reason for Hospitalization: _____

Details of Hospitalization:

Patient`s Hospital Registration No: _____ *Time of Admission:* _____

Date of Admission: _____ *Date of Discharge:* _____

Type of Room/Ward: _____ *Bed No:* _____

Diagnosis*(in medical terminology)*: _____

S.No	*Receipt No*	*Date*	*Type of Charges(In Detail i.e. Breakup)*	*Amount(In Rs)*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
Grand Total				**Rs.**
Amount in words:				

Date:_____

_____

Signature of Treating Doctor with Stamp

PMDC Registration No:_____

INSTRUCTIONS FOR FILLING THE FORM {To be observed strictly}

DOCUMENTS REQUIRED:-

1. **IPD Claim Form** *Original (Completely Filled)*
2. **Hospital Payment Receipts/Bill** *Original (Details of payments being charged should be mentioned on the receipt/bill i.e. break-up of payment)*
3. **Doctor`s Notes or Discharge Slip/Card/Summary** *Original (Mentioning Chief Complaints, diagnosis, course of treatment along with other hospitalization details)*
4. **Hospital Intimation Form** *Original (Faxed form showing estimate approval by SICL-Health Department)*
5. **Medicine Receipts** *Original (Purchased during IPD, Pre/Post Hospitalization Treatment)*
6. **Investigation Reports** *if any Original*
7. **Birth Certificate** *for maternity cases where live baby is born Copy (Proper printed certificate with Hospital clinic insignia. Completely filled and attested by a gazetted officer)*
8. **Shaheen Health Card & National Identity Card** *Copy (They should be valid at time of presentation)*

NOTE:-

- *Kindly photocopy all claims being sent to our office and maintain them in your record for future reference.*
- *No Overwriting or Additional Changes to already prescribed prescriptions/receipts is allowed.*
- *No Prescriptions/Receipts are allowed to be claimed on blank papers having no title of the chemist/doctor/hospital.*
- *`Hospital Intimation Form` is exempted for clients having an emergency or a condition where there is threat to human life i.e in case the treatment is not provided instantly, when Shaheen Health Department is closed but Intimation approval should be taken from Shaheen Health department as soon as possible on the next working day.*
- *For Panel Hospitals(If it`s holiday/Non-working Day), in case of emergency, the patient can be treated or hospitalized instantly as per requirement of patient after assessment by Doctor with security deposit from patient (for 1 day treatment or as required) which will be refundable after receiving a `Hospital Intimation Form` approval from SICL on the next working day according to the approved amount.*
- *To avoid delays, for IPD cases, seek approval of estimate amount via `Hospital Intimation Form` before admission.*
- *All medicine cost/bills incurred will be checked with rate lists provided to us via hospital/clinics and chemists(Rate lists updated every 15 days)*
- *Claims presented after 15 days of expiry of policy period will not be re-imbursed.*
- *IPD claim expenses incurred should be claimed within 1 month.*
- *In case of lack of documents submitted for claim re-imbursement, they should be submitted within 1 month after receiving letter for their submission or the claim will stand refused/rejected after expiry of period of 1 month.*

Dr.Shaan Khan
CMO
SICL-ISB