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Medical Claim for Treatments and Referrals

IMPORTANT NOTES

1. This form **MUST** be dully completed and signed by the patient and attending Doctor
2. Attach original invoices, receipts and copies of prescriptions to the claim form
3. Medication/drugs bought over-the-counter will not be re-imbursed by the scheme
4. Claims received after 60 days from treatment date will not be honoured
5. Patients Must identify themselves with a First Med photo card
6. Incomplete claim forms will delay settlement of claims

PATIENTS PARTICULARS

Surname _____ First Names _____ Age _____ Membership No. _____

Employer _____ Policy No. _____

Name of Member (if patient is a dependant) _____ ID/Passport _____

Patients Relationship with member/employee _____

Are you insured under any medical expense scheme/Work compensation/Personal Accident? YES NO

(If so please give details) _____

Are you a member of National Hospital Insurance Fund? YES NO

CONSULTATION/REFERRALS TO SPECIALIST AND HOSPITAL ADMISSION

(SICKNESS TO BE COMPLETED BY ATTENDING DOCTOR)

NATURE OF SICKNESS / AILMENT _____

WHEN DID IT FIRST OCCUR _____

NATURE OF TREATMENT _____

IN YOUR OPINION, WHAT IS THE CAUSE OF THIS AILMENT _____

IN YOUR OPINION, IS THIS AILMENT CHRONIC / RECURRING? _____

SPECIALIST REFERRED TO _____

DETAILS OF MEDICAL EXPENSE

OUTPATIENT:

(Attach receipted accounts within 60 days)

Number of Consultations _____

Consultation Fees _____

Cost of prescribed drugs
(Attach copy of prescription) _____

Cost of injection/procedure _____

Other expenses
(X-ray, Laboratory test etc) _____

TOTAL

IN PATIENT:

(Attach receipted accounts within 60 days)

Hospital confinement: From _____ To _____
 No. of days: _____

Accommodation charges _____

Operation charges: DR. _____

Anaesthetist Fee: Dr. _____

Prescribed Drugs. _____

Other expenses incurred while in hospital _____

TOTAL

NAME OF ATTENDING DOCTOR _____

ADDRESS OF PRACTICE _____ DR. SIGNATURE _____

Date & Stamp _____

Declaration: I warrant the truth of the above statement. I have not withheld /misstated any material information relating to this claim and have no objection to First Assurance and/or their representatives communicating with my medical Doctor/Physician or Hospital I have consulted or visited. I guarantee to pay any expenses not covered by my insurance plan or in excess of the limit provided under my plan or any deductible or co-pay determined by this plan.

Members Signature _____ **Date:** _____

FIRST MED GENERAL EXCLUSIONS

1. Elective or planned surgery within 3 months of membership
2. Expenses incurred by member out of self inflicted injury or attempted suicide
3. Treatment of Obesity and slimming preparations
4. Patent foods or baby food, and similar aids, sunscreens, shampoos and Skin cleansing remedies. Acne treatment, beauty products
5. Domestic and Biochemical remedies
6. Cosmetic procedures including but not limited to Gastroplasty, bat ears, blephroplasty, breast augmentations, dermabrasions, liposuction, part and /or full nasal reconstructions, lipectomies, face lifts, revision of scars or such other procedures that the Medical Advisor deems cosmetic, except in the event of Trauma or Cancer
7. Cosmetic treatment and plastic surgery, whether or not for psychological purposes, including treatment for obesity investigative procedures or treatment of a routine nature, unless arising from an accident
8. Treatment for injuries arising out of Voluntary participation in riots, demonstrations, unrest and civil or other wars
9. Medical examinations for employment, insurance or physical fitness purposes or costs in respect of examinations and inoculations for international; travel as well as food handlers' examination
10. Travel expenses other than emergency ambulance costs
11. Injury or sickness caused by Alcohol or drug abuse
12. Holidays for recuperative purposes
13. Private Nursing or Residential stay in a private Hospital or Health Hydros
14. Patent / proprietary drugs (drugs available to the general public without a prescription) Homeopathic drugs
15. Stop smoking aids
16. Vitamins, tonics, and mineral supplements, herbal treatment/supplements
17. Treatment for infertility and artificial insemination
18. Costs relating to Contraception and or sterilization
19. All costs in respect of Pre-Existing conditions that were specifically excluded in writing when the member joined the Medical Plan or which were not disclosed on the members application form
20. All costs relating to the Purchase of medicines prescribed by a person not registered as a medical practitioner, legally entitled to prescribe such medicines
21. All costs arising out of injuries sustained whilst participating in professional sports e.g. bungee diving, motor sport racing boat racing etc
22. Costs relating to HIV infection or AIDS unless registered under the Health Is Vital Programme and covered under the chronic medication programme
23. Costs relating to Sexually transmitted diseases including opportunistic diseases
24. Costs relating to Circumcision
25. Costs relating to Immunosuppressant drugs
26. Costs relating to Non Medical treatment
27. Any costs pertaining to maternity benefits relating to child beneficiary here in referred to as Third generation pregnancies which are excluded in full
28. All costs by which the Annual limits of a member or dependant in respect of the relevant options are exceeded for any treatment
29. All costs relating to the difference in recommended tariff and the tariff actually charged by the Contacted Preferred Service provider
30. Any Dental, Optical, Physiotherapyphysio equipment e.g. clutches), MRI & CT Scans or Hospital admission which no Pre-Authorization approval form has been given by the FACL