First Assurance

FIRST MED

A Healthy Choice!

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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)*		**IN PATIENT:** *(Attach receipted accounts within 60 days)*	
Number of Consultations		**Hospital confinement:** From _____ To _____ No. of days: _____	
Consultation Fees		Accommodation charges	
Cost of prescribed drugs *(Attach copy of prescription)*		Operation charges: DR.	
Cost of injection/procedure		Anaesthetist Fee: Dr.	
Other expenses *(X-ray, Laboratory test etc)*		Prescribed Drugs.	
		Other expenses incurred while in hospital	
TOTAL		**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:** _____