MEDICAL EXPENSE - CLAIM FORM

SECTION 1 : CLAIMANT STATEMENT
(To be filled by the Claimant)

POLICY PARTICULARS

Name of Company : _____

Name of Employee : _____ **Emp. ID** : _____

Name of Patient : _____ **CNIC # of Patient** : _____

Age of Patient : _____ **Wellness Card No.** : _____

Relationship with Employee : _____ **Policy No.** : _____

DETAILS OF ILLNESS ☐ Pre & Post Hospitalization ☐ OPD ☐ Hospitalization

Date of illness first noticed : _____ **Date of recovery** : _____

Diagnosis : _____

Has the claimant suffered from this illness before? Yes / No **(If yes, please give date(s) and details below)**

_____

_____

_____

TOTAL AMOUNT OF CLAIM ☐ Pre & Post Hospitalization ☐ OPD ☐ Hospitalization

Please list in the column below all expenses claimed and attach original (not photocopies) of all relevant paid receipt supported by relevant prescriptions and discharge summary

Sr. No.	Receipt No.	Date	Name of Expense	Patient's Name	Relationship with Employee	Amount (in PKR)
Total						