REIMBURSEMENT FORM

Name: _____ Membership No.: _____

Corporate _____

Claimed amount: _____

Beneficiary _____

Bank Details _____

Referred to AAR Claims by: _____

Name **Signature** **Date**

☐ Claim submitted within 60 days (over 60 days is stale)

Pay from: ☐ Fund ☐ Insurance (OP, IP) ☐ Ex-Gratia

☐ Has the benefit/valid

Reason for reimbursement: _____

_____

_____

☐ Medical report attached
☐ Invoice/ receipt attached has all breakdowns
☐ If overseas only emergency and evacuation are covered. OP not covered.
☐ If overseas only covered if within 90days since leaving East Africa
☐ If IP, was admission reported?
☐ If IP, attach Reimbursement pre-authorization letter?

To be filled by Claims Dept

☐ If IP Accrued? How Much?
☐ Charges as per AAR rates?
☐ NHIF rebate is deducted

Reimbursement Amount: _____

Foreign Currency **Exchange Rate** **Kshs:**

Approved by:

Medical Assessor

_____

Name **Signature** **Date**

Medical Services Manager

_____

Name **Signature** **Date**