CIC GENERAL INSURANCE LTD.

OUT PATIENT CLAIM FORM

299984

CIC GROUP

PATIENT'S INFORMATION

Scheme Name: Employee's Name:

Membership No : National ID (must provide):

Patient mobile number: Email:

Patient's Name: Date of Birth:

Relationship of patient to Employee: (Tick against the box): Spouse: Child: Self:

MEDICAL INFORMATION

Type of condition (Tick against the box): ACCIDENTS: SICKNESS:

SERVICE PROVIDER DETAILS

Name of Clinic: Consulting Physician:

Treatment Date:

DIAGNOSIS CODING

DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)
ALLERGIC RHINITIS	J30	C-SECTION	O82	MALARIA	B54	PHARYNGITIS	J02
ANAEMIA	D64	DENTAL CARIES	K02	MYOPIA	H52	PNEUMONIA	J18
ANTENATAL SCREENING	Z36	DERMATITIS	L30	OPTICAL EXAMINATION	Z01	SPONTANEOUS BIRTH	O80
BRONCHITIS	J40	DIARRHOEA/GASTRO	A09	OF EYE AND VISION		TONSILLITIS	J03
CANDIDIASIS	B37	GASTRITIS	K29	OTITIS MEDIA	H66	URTI	J06
CONJUNCTIVITIS	H10	INFLUENZA	J10	PEPTIC ULCER	K27	UTI	N39
VACCINATION	Z23	POSTNATAL	Z39.0	HPT	I18.9	DM	E08.9

Other:

Consultation	0190-GP	0191-SPECIALIST	11001-OPTICAL	8101-DENTAL	Other		Cost	

Is this a Maternity Related Claim? Yes No

SERVICE PROVIDED		DESCRIPTION				COST
LABORATORY TESTS						
OTHER DIAGNOSTIC PROCEDURES / TESTS						
OPTICAL						
DENTAL						
PRESCRIBED DRUGS (ATTACH COPY OF PRESCRIPTION)		QTY	DOSAGE	DESCRIPTION		

PROVIDER'S DECLARATION

I certify that the above patient has received the services & treatment noted on this form, diagnosed and administered by myself and that this claim is in accordance with my specified treatment.

Doctor's Name: Signature: Date:

I _____ do hereby authorize any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and / or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. In the event that I access service which is not covered by my scheme or in the event that my scheme fails to pay the bill, I undertake to settle the bill in full within the provider's credit terms.
I have also been advised by CIC Insurance and have understood the various exclusions. Any photocopy of this authorization shall be taken as the original copy.

Patient/Parent/Guardian's Signature: Date: