# REIMBURSEMENT **CLAIM FORM**

Kindly ensure ALL the Mandatory Documents below are submitted to form part of this application form:

Duly filled outpatient/reimbursement claim form ☐ Copy of drug prescription form ☐ Original receipts ☐

Copy of lab request form ☐ Breakdown of the charges ☐ Registered Mpesa Mobile Number ☐

Bank details of the principal member ☐

**The Mpesa limit for reimbursement is Kes. 70,000. For any amount exceeding this limit, a bank transfer will be made.*

| | |
|---|---|
| Practitioners Name: | |
| Postal Address: | |
| Tel No.: | Mobile: |
| Email: | |

**Practitioner's Official Stamp**

## PATIENT'S PARTICULARS

| | | | |
|---|---|---|---|
| Full Name of Patient: | | Date of Birth: | |
| Full Name of Member (if patient is a dependant): | | Date of Birth: | |
| Member's Mpesa Registered Mobile No.: | | Member No. | |
| Member's Employer Name: | | Dept. /Branch | |
| Have you suffered from this sickness in the past? | YES | NO | |
| If YES, when did it start and how frequent is it? | | | |

## MEMBER BANK ACCOUNT DETAILS FOR REIMBURSEMENT

| | | | |
|---|---|---|---|
| Account Name: | | | |
| Account Number: | | | |
| Bank Name: | | Branch Name: | |
| Swift Code/BAC (For international payments): | | | |

## CONSULTATION/REFERRALS

## DIAGNOSIS:

**TREATMENT PRESCRIBED**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **MEDICINES:** | Prescription | | Injection given | | Dispensed | | None | |
| **RADIOLOGY:** | X-Ray | | MRI/Cat Scan | | Other | | Other | |
| **PATHOLOGY:** | Haemotology | | Microbiology | | Biochemistry | | Histology | |

Hospital Name: _____ Consultant Referred To: _____ Specialty: _____

**MEDICATION PRESCRIBED:**

_____

_____

**Dr's Signature** _____ **Date** _____

**DECLARATION**

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

**Member's Signature** _____ **Date** _____

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