

Outpatient Treatment Claim

Patient Information

Patient Name:

[REDACTED]

Policy Number:

[REDACTED]

Date of Birth:

[REDACTED] / [REDACTED] / [REDACTED]

Contact Number:

[REDACTED]

Email Address:

[REDACTED]

Visit Details

Clinic / Hospital Name:

[REDACTED]

Date of Treatment:

[REDACTED] / [REDACTED] / [REDACTED]

Attending Doctor:

[REDACTED]

Diagnosis:

[REDACTED]

Claimed Expenses

#	Description	Date	Amount
1	[Consultation Fee]	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED]
2	[Medication]	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED]
3	[Lab Test]	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED]
Total			[REDACTED]

Bank Details for Reimbursement

Account Holder Name:

[REDACTED]

Bank Name:

[REDACTED]

Account Number:

[REDACTED]

Declaration

I hereby declare that the information provided above is true and correct to the best of my knowledge. I have not received reimbursement for these expenses from any other source.

Signature of Patient/Claimant

Date: [____ / ____ / ____]

Signature of Attending Doctor

Date: [____ / ____ / ____]