Outpatient Treatment Claim

Patient Information

Patient Name:

[_____]

Policy Number:

[_____]

Date of Birth:

[_____/_____/_____]

Contact Number:

[_____]

Email Address:

[_____]

Visit Details

Clinic / Hospital Name:

[_____]

Date of Treatment:

[_____/_____/_____]

Attending Doctor:

[_____]

Diagnosis:

[_____]

Claimed Expenses

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

Bank Details for Reimbursement

Account Holder Name:

[_____]

Bank Name:

[_____]

Account Number:

[_____]

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: [_____/_____/_____]