# Outpatient Treatment Claim Application

## 1. Patient Details

Patient Name

Date of Birth

Member ID / Policy No.

Contact Number

## 2. Treatment Details

Clinic/Hospital Name

Date of Treatment

Diagnosis

Treatment/Medication Provided

## 3. Claim Details

| **Description** | **Amount Claimed** |
|---|---|
| Consultation fee | |
| Medicine | |
| Laboratory Test | |
| Other (specify below) | |
| **Total** | |

Other Details (if any)

## 4. Bank Details

Bank Name

Branch

Account Number

Account Holder Name

## 5. Declaration

I hereby declare that the information given above is true and correct to the best of my knowledge and belief. I authorize the insurer to obtain necessary information from my doctor/hospital for processing this claim.

Signature of Claimant
(Patient/Guardian)

Date