Outpatient Treatment Claim Form

Patient Details

Full Name

Date of Birth

Gender

Health Insurance ID

Address

Treatment Details

Date of Treatment

Clinic / Hospital Name

Diagnosis

Treatment / Services Provided

Attending Doctor

Doctor Registration Number

Claim Details

Total Claim Amount

Currency

Bank Details for Reimbursement (Bank Name & Account No.)

Declaration

I certify that the information provided is true and accurate to the best of my knowledge.

Claimant's Signature

Date