CLAIM EXPENSE FORM

(Medical, Dental, Vision)

A. EMPLOYEE'S SECTION

Member No.: __________________ Employee No.: _______________________ Birth date: ______________________

Patient Name: ____ State Nature of Illness: __________________________

Country of Treatment: __________________________________ Date of Treatment: _____________________________

Pay to (Name): _______________________________________ Email address: ________________________________

Bank Account No: ____________________________________ Bank Name: __________________________________

Mailing Address: ____

(Settlement cheque will be deposited where possible or will be mailed to this address)

Authorization: I the undersigned, hereby certify that all answers and all documents submitted with this Claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me and/or any of my family members to provide SAICO with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

BREAKDOWN OF EXPENSES (compulsory)	**CURRENCY**:	
Dr's FEES (consultation)		
MEDICINES		
OTHERS (lab, X-Rays, dental, vision, etc)		
TOTAL AMOUNT CLAIMED:		

Member's signature: _________________ Date: ________________ Contact No.: ______________________________

B. PHYSICIAN'S SECTION

Patient name (CAPITALS): ____ Age: _____________

Diagnosis (CAPITALS): ____ ICD: _____________

Type of treatment: [ ] Illness Date first seen ____________________

[ ] Accident Work Related YES / NO Date: ____________________ Time: _____________

Cause: _______________________________ Place: ___________________

[ ] Pregnancy Date of LMP: ________________ Expected delivery date: ________________

[ ] Hospitalization Date admitted:________________ Date discharged: _____________________

PHYSICIAN'S DECLARATION: I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.

Physician's Stamp: _____________________________ Signature: ____________________ Date: ________________

C. ATTACHMENTS REQUIRED

1. Invoices with proof of payment.
2. Doctor's prescription for medicines, lab tests, X-rays etc.
3. Pharmacy invoice clearly showing name of medicine, quantity purchased and price of each medicine.
4. Copy of patient's SAICO membership card.

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