PLAN HEALTH

GENERAL PRACTITIONER FEES REIMBURSEMENT FORM

INSTRUCTIONS:

1. Complete ALL information requested below.
2. Enclose ORIGINAL bills.
3. Please keep a copy for your records.
4. Reimbursement form should be submitted within one week of consultation.

IS THE REQUEST FOR: Self ☐
Family Member ☐

Sr. No	Name	Customer ID	Service Date	Diagnosis	Treatment Given	Consultation Cost	Doctor's Name,Sign and Stamp with Registration No.

Authorized member: - Member ID: **Name and sign:**