STATE LIFE

INSURANCE CORPORATION OF PAKISTAN

CLAIM REIMBURSEMENT FORM

HEALTH INSURANCE CLAIM REIMBURSEMENT FORM

Type of Claim ☐ Pre-Hospitalization Expense ☐ Hospitalization/Daycare Expense ☐ Post-Hospitalization Expense ☐ OPD

☐ Pre-natal Expense ☐ Maternity Expense ☐ Post-natal Expense

Claimant Name:	Plan Name:
Participant/Employer Name:	Plan Start Date: ☐☐•☐☐•☐☐ Plan End Date: ☐☐•☐☐•☐☐

Patient's Name:		Patient's Gender: ☐ Male ☐ Female	
Patient's Health Card Number:		Patient's Date of Birth: ☐☐•☐☐•☐☐	
CNIC: ☐☐☐☐☐–☐☐☐☐☐☐☐–☐	Phone Residence:	Phone Office:	Mobile:

1. State the nature of the medical condition, injury, illness:	
2. On what date did the symptoms first occur? ☐☐•☐☐•☐☐	CNIC Number of Claimant: ☐☐☐☐☐–☐☐☐☐☐☐☐–☐
3. Name and address of physician/health provider who was first consulted due to above mentioned medical condition?	
4. Has the patient consulted any doctor for the above mentioned medical condition? If "yes", for each doctor and hospital consulted. state name, date of consultation, reason for consultation and treatment provided.	
5. Is this claim related to an accident? ☐ Yes, ☐ No If "yes". what was the date of the accident?	
Give brief details of where and how accident occurred?	
6. Give details of any other health, medical or travel Takaful / Insurance, workman's compensation, social security or other medical benefits to whichthe patient may be entitled	

Name of Hospital/Clinic where treatment was availed:		
Date of Consultation: ☐☐•☐☐•☐☐	Date of Discharge: ☐☐•☐☐•☐☐ IF APPLICABLE	Total Nos: of days: In case of admission
Total Amount of Claim (In Pak Rupees):		

DECLARATION & AUTHORIZATION

I hereby certify that all answers to questions appearing on this form and documents submitted with this form are true and complete to the best of my knowledge and belief.
I, the above claimant, hereby authorize any doctor, hospital, clinic or medical service provider, takaful/insurance company, or any other institution, or any person, who has any information or record about me and/or any of my dependents to provide state life insurance corporation of Pakistan with the complete information including copies of their records with reference to any sickness, accident, disability treatments, examination, medical investigation, advice of healthcare provider.

Date of Statement: ☐☐–☐☐–☐☐☐☐

Signature of claimant/Individual Member
Primary Participant/Employee will complete and sign this form on behalf of minor child

TO BE FILLED BY MEDICAL PRACTIONER

Patient's Name:		
Patient's Health Insurance Number:		Patient's Gender: ☐ Male ☐ Female
CNIC: ☐☐☐☐☐–☐☐☐☐☐☐☐–☐	Patient's Date of Birth: ☐☐•☐☐•☐☐	

1.How long have you been the patient's doctor?	
2. On what date were you first consulted for the injury, illness or medical condition concerned or for any related condition?	
3. Please give your diagnosis of the injury/illness/condition?	
4. Do you have any reason to believe that the same or any related condition has been diagnosed or treated previously by any other doctor or hospital?	
5. Has the patient consulted any doctor for the above-mentioned medical condition? If "yes", for each doctor and hospital consulted. state name, date of consultation, reason for consultation and treatment provided.	
6. Please give details of the treatment given or prescribed?	

For Maternity Case Only:

1. Duration of Pregnancy? ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester	weeks
2. Would normal delivery endanger the life of mother and/or child(ren) and intra-abdominal surgery necessary for extra uterine pregnancy or complications: ☐ Yes ☐ No if "Yes", please give reason in detail:	
3. Is there any pernicious vomiting in pregnancy, toxemia with convulsion or spontaneous abortion? ☐ Yes ☐ No if "Yes", please give reason in detail:	

DECLARATION

i/We hereby certify that all answers to questions appearing on this form are true and complete to the best of my/our knowledge

Date of Statement: ☐☐–☐☐–☐☐☐☐

Signature/Stamp of Treating Physician

Name of Physician:	**PMDC Number:**
Address of Hospital:	**Contact Details:**

IMPORTANT: In order to avoid delay, please ensure that

- Use a New Claim form for each claim or course of treatment
- The Individual Covered or his/her legal representative must complete all question of the claim form and sign it
- The treating physician must complete all questions of Part B of the claim form and sign it.
- Please recheck and send completed claim form with all relevant document(s)/Report to State life Insurance Corporation of Pakistan. Please be informed that;
- Incomplete claim form will not be accepted for processing of payment
- Ensure to attach ORIGINAL bills, receipt of payments, and investigation reports.
- PHOTOCOPIES are not acceptable for processing of claim