Adamjee Insurance Company Limited

Health Insurance Claim Form

INSTRUCTIONS: (Please read them carefully)

1. In order for us to provide you with efficient services, please complete the form accurately in "CAPITAL LETTERS"
2. Filled forms should be sent to Adamjee Insurance Company Limited within 30 days of the expense incurred date.

Employee Details (To Be Filled by the Employee)

Name of Employee: _____ Bank Account Title: _____

Name of the Patient: _____ Relation with Employee: _____

Name of the Company: _____ Auth Letter No.: _____

Employee ID: _____ Contact # : _____ CNIC # _____ -- _____ -- _____

Note: Please attach the copy of your updated health card at top of the claim

Out Patient Claim (OPD)

Documents Attached with the Claim
☐ Bill(s) (Original)
☐ Prescription(s) (Copy)
☐ Lab Report(s) (Copy)

Note: In case of more space required attach another claim form.

Sr #	Patient Name	Relation with Employee	Amount (PKR)
Total Amount Claimed			

Hospitalization / Pre & Post Hospitalization Claim (IPD)

Documents Attached with the Claim
☐ Hospital Bill (Original)
☐ Discharge Summary (Copy)
☐ Birth Certificate (In case of Birth)
☐ Lab Reports (Copy)
☐ Pharmacy Bills (Original)
☐ Prescription (Copy)

☐ Hospitalization ☐ Maternity ☐ Pre / Post Hospitalization

Name of Hospital: _____

Name of Treating Doctor: _____

Date of Admission: _____ Date of Discharge: _____

☐ Emergency ☐ Elective

Has the claimant suffered from this illness before? ☐ **YES** ☐ **NO**

Claimed Amount:

Disclaimer: Please note that In Case of any of the above document missing the claim will not processed.

DECLARATION:

I hereby declare that all the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Adamjee Insurance Company Limited, to seek necessary medical information / documents from any hospital / medical practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim in accordance to the checklist mentioned and that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any. Any photocopy of this declaration shall be taken as the original copy.

_____ Signature of the Employee

_____ Signature/Stamp of the HR

To be filled by attending physician/hospital *(In Case of HOS/MAT)*

Patient's Name: _____

Final Diagnosis: _____

Procedure: _____

I hereby certify that my answers to the above questions are correct and true to the best of my knowledge and belief:

_____ Mobile No. & Address

_____ Signature/Stamp of Doctor

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