SARCHI
INSURANCE AGENCIES LTD

CLAIM FORM
(Out-Patient)

Practitioners Name _____ Practitioners Official Stamp

_____

Postal Address _____

_____

Tel _____ Mobile _____

Fax _____

PATIENT'S PARTICULARS

Full Name of Patient _____ Date of Birth _____

Full Name of Member (if patient is a dependent) _____

Policy No. _____ Member No. _____

Member's Employer Name _____ Dept/Branch _____

Date _____

_____

1) Have you suffered from this sickness in the past? YES ☐ NO ☐

If YES, when did it start and how frequent is it? _____

CONSULTATION/REFERRALS

DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription	☐	Injection given	☐	Dispensed	☐	None ☐
RADIOLOGY:	X-ray	☐	MRT/cat Scan	☐	Other	☐	Other ☐
PATHOLOGY:	Hematology	☐	Microbiology	☐	Biochemistry	☐	Histology ☐

HOSPITAL NAME: CONSULTANT REFERRED TO: SPECIALITY:

MEDICATION PRESCRIBED

_____

Dr's Signature _____

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature _____ Date _____