CO-OPERATIVE BANK
We are you

Form S13 (b)

Medical Claim Form

A. PATIENT DETAILS (*to be completed by patient/parent/guardian*)

Patient Name: ……..…….……..…..

Patient membership number (*Appears on the smart card*): ……..…….…

Principal member name (staff): …..……..……..……..

B. MEDICAL CERTIFICATE (*to be completed by the attending medical practitioner*)

Provisional/Final DX: ……..……

Prescription (drugs/dressing/Injection etc.)
(A separate prescription can also be attached) Quantity

…… ……
…… ……
…… ……
…… ……
…… ……
…… ……

I certify that I have seen the above named person and that the information provided above is correct to the best of my knowledge:

Doctor/Medical Officer's Name	**Signature of the Doctor/Medical Officer**	**Date**	**Stamp of Health Facility**

Patient/Guardian Signature: …… **Date: …….**

IMPORTANT

Please attach the following documents while submitting the claim:

1. *Completed medical claim form (all spaces MUST be completed)*
2. *Original invoice(s)/receipts showing Itemized cost of treatment/drugs per patient.*
3. *Prescription (this MUST be provided separately where prescription in not captured on the claim form)*

All claims should be sent to:

Physical address: *Co-op Bank-HR Department, Co-optrust Plaza, Bunyala Road, Nairobi*
Postal address: *P.O. Box 48231-00100 GPO, Nairobi*
Medical support Hotlines: 0711 013 217/0711 013 699
Email contact: *medicalmanagers@co-opbank.co.ke*