BLUE
Healthcare that works where you work
www.libertyhealthblue.com

Heritage
Insurance Company
A member of LIBERTY

CLAIM FORM

BLUE INVOICE NUMBER

THIS FORM MUST BE COMPLETED FOR EVERY PATIENT RECEIVING TREATMENT. PLEASE COMPLETE A SEPERATE CLAIM FORM FOR EACH VISIT AND ATTACH YOUR INVOICE FOR PROCESSING. THE PATIENT SHOULD BE GIVEN A DUPLICATE COPY FOR THEIR RECORDS. PLEASE ATTACH DETAILED INVOICE WHERE POSSIBLE TO EXPEDITE PAYMENT.
PLEASE COMPLETE FORM IN BLOCK LETTERS.
IMPORTANT: THE HERITAGE INSURANCE COMPANY KENYA LTD WILL DECLINE ILLEGIBLE OR INCOMPLETE CLAIMS

PATIENT DETAILS

FIRST NAME SURNAME

MEMBER NO. DEP CODE GENDER M F DOB D D M M C C Y Y

MAIN MEMBER DETAILS

FIRST NAME SURNAME

EMPLOYER

SERVICE PROVIDER DETAILS

NAME OF PROVIDER CONSULTING PHYSICIAN

HERITAGE PROVIDER NO TREATMENT DATE D D M M C C Y Y

SHOULD HOSPITALISATION BE REQUIRED PLEASE COMPLETE A HOSPITALISATION PRE-AUTHORISATION FORM

DIAGNOSIS CODING

DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)
ALLERGIC RHINITIS	J30	C-SECTION	O82	MALARIA	B54	PHARYNGITIS	J02
ANAEMIA	D64	DENTAL CARIES	K02	MYOPIA	H52	PNEUMONIA	J18
ANTENATAL SCREENING	Z36	DERMATITIS	L30	OPTICAL EXAMINATION OF EYES AND VISION	Z01	SPONTANEOUS BIRTH	O80
BRONCHITIS	J40	DIARRHOEA/GASTRO	A09			TONSILLITIS	J03
CANDIDIASIS	B37	GASTRITIS	K29	OTITUS MEDIA	H66	URTI	J06
CONJUNCTIVITIS	H10	INFLUENZA	J10	PEPTIC ULCER	K27	UTI	N39

OTHER (SPECIFY DIAGNOSIS)

CONSULTATION	0190 GP	0191 SPECIALIST	11001 OPTICAL	8101 DENTAL	OTHER	**COST**
IS THIS A MATERNITY RELATED CLAIM?				Yes	No	

SERVICE PROVIDED	CODE	DESCRIPTION	COST
LABORATORY TESTS			
OTHER DIAGNOSTIC PROCEDURES/TESTS			
OPTICAL			
DENTAL			
PRESCRIBED DRUGS (ATTACH COPY OF PRESCRIPTION)	CODE / QTY / DOSAGE	DESCRIPTION	
		TOTAL MEDICAL COSTS (INDICATE CURRENCY)	

PROVIDER'S DECLARATION

I CERTIFY THAT THE ABOVE PATIENT HAS RECEIVED THE SERVICES & TREATMENT NOTED ON THIS FORM, DIAGNOSED AND ADMINISTERED BY MYSELF AND THAT THIS CLAIM IS IN ACCORDANCE WITH MY SPECIFIED TREATMENT.

SIGNED **DATE** D D M M C C Y Y

PROVIDER STAMP

PATIENT'S / PATIENT'S GUARDIAN DECLARATION

I _____ HEREBY DECLARE THE ABOVE STATED TO BE TRUE AND IN ACCORDANCE WITH THE MEDICAL SCHEME RULES. I CONFIRM THAT THE DETAILS GIVEN ABOVE ARE CORRECT, THAT THE AMOUNT CLAIMED HEREIN IS NOT CLAIMABLE FROM ANOTHER SOURCE, AND THAT THE PATIENT IS A MEMBER OR DEPENDANT ON BLUE HEALTH INSURANCE. I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS TO BLUE FOR ITS CONFIDENTIAL USE AND I AGREE THAT NO AWARDS WILL BE MADE FOR THIS TREATMENT UNLESS CONTRIBUTIONS ARE RECEIVED IN RESPECT OF THE PERIOD OF TREATMENT. THE HERITAGE INSURANCE COMPANY LTD RESERVES THE RIGHT TO RECOVER ANY AMOUNTS PAID TO PROVIDERS IN EXCESS OF BENEFITS DIRECTLY

SIGNED (PATIENT/GUARDIAN)

CELL PHONE NO. **DATE** D D M M C C Y Y

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