KCB | KCB OUTPATIENT MEDICAL CLAIM FORM

PART 1: TO BE COMPLETED BY STAFF			
Name of Employee:		**Staff No.:**	
Branch:		**Division:**	
Name of Dependant Being Treated:		**Relation:**	***Tick as appropriate*** Self ☐ Spouse ☐ Child ☐
Date of Birth of Person Being Treated:		**Medical card No. of Person Being Treated:**	

PART 2: TO BE COMPLETED BY DOCTOR SERVICE PROVIDER

Exact Nature of illness or Accident:

Is condition Work Related Or Occupational Illness?

If Work Related/Occupational Illness, state when the condition was first diagnosed:

Briefly explain or attach explanation in the case of Work Related/Occupational Illness:

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Please attach all receipts/invoices and copies of prescriptions relating to this as listed here below:

ITEM	**COST-KSHS**	**CTS**	**BILLS/RECEIPTS NOs/ REF**
CONSULTATION/HOSPITAL CARE			
LABORATORY/X-RAY/DIAGNOSTIC			
DENTAL/OPTICAL EXPENSES			
MEDICINES/DRUGS/INJECTIONS			
OTHER (SPECIFY)			
TOTAL			

Note: No payment will be made for pharmacist bills unless they relate to prescribed medications *(attach prescriptions where applicable)*

EMPLOYEE CERTIFICATE

I hereby declare that all information stated above is true and complete and that no information has been omitted. I consent to the company seeking information from any doctor I or my dependants have consulted.

Signed: ____________________ Date: __________

MEDICAL PRACTITIONER'S CERTIFICATE

I certify that the above amounts are in accordance with my specified treatment and to the best of my knowledge and belief the claim is valid for payment/reimbursement

NAME & QUALIFICATIONS: ____________________

Stamped & Signed: ____________________ Date: __________

PAP.1119 KCB MEDICAL CLAIM FORM (2013)

IMPORTANT

1. Claim form to be completed by Medical Practitioner
2. Attach original invoices/receipts and copies of prescriptions to Claim Form

Regulated by the Central Bank of Kenya