

MEDICAL CLAIM FORM

WARNING

Falsified information is classified as intended fraud and shall be reported to the Insurance Fraud & Investigation Unit (IFIU) for criminal prosecution. Exclusions listed on reverse of this form.

AN INCOMPLETE CLAIM FORM WILL RE	SULT IN RE	JECTION OF THIS CLAIM	
HOSPITAL/SERVICE PROVIDER NAME			
CONTACT NUMBER(S)		EMAIL	
GENERAL CONDITIONS			
1) ALL sections of this form must be clearly filled (BLOC 2) A separate claim form must be filled for each visit 3) Attach all medical bills and supporting documents as 4) Reimbursement claims after 60 days from date of se 5) Claims received after 90 days from date of treatment	s pertains to the pervices will be time	e barred	
PERSONAL INFORMATION (Enter as displa	yed on the pa	tient's MADISON card)	
NAME OF PATIENT		DATE OF BIRTH:	
PATIENT MEMBERSHIP No.		PATIENT/PARENT/GUARDIAN PHONE No.	
EMPLOYEE NAME/PRINCIPAL MEMBER		RELATIONSHIP WITH PATIENT	SPOUSE PARENT SELF
COMPANY/SCHEME			
CLINICAL INFORMATION (To be complete	d by the atten	nding medical practitioner/consul	tant)
Type of condition (Tick as appropriate) SICKNESS IF SICKNESS,	ACCIDENT		
Preliminary Diagnosis 1.	2.	3.	4.
Final Diagnosis 1.	2.	3.	4.
When was the condition first diagnosed?			
In your opinion, what is the cause of this illness?		In your opinion, is the illness Chroni	c YES NO Recurring YES NO
		Congenit	al VES NO.
IF ACCIDENT, Nature of injuries		Date of Accident	
Cause of accident		Location	
Was the patient referred to a Specialist? YES NO			
If Yes, Name of Consultant	Specialty	Location:	
DECLARATION			
I declare that the information provided on this for General Insurance Kenya Ltd and its appointed reg in relation to this claim, from any third party, inclu- misrepresentation or omission of material facts material facts	presentatives the iding providers a	e right to request past, present and futu and medical practitioners. I understand	re medical information that any deliberate
	SIGN		
I hereby certify that the above treatment was administered b	y me to the patient	or was carried out at my instruction by other pr	actitioners or establishments.
DOCTOR'S NAME		Qualification(s)	
SIGN DOTED		SEVILLY:-	STAMP

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