Minet

AON | Global Network Correspondent

OUTPATIENT MEDICAL CLAIM FORM

PATIENT'S INFORMATION

Name of Employer:

Full Name of Employee:

Mobile Number: Medical Card No.: Date of Birth:

Full Name of Claimant:

MEDICAL INFORMATION

Exact nature of illness/accident/medical application e.g. wheelchair:

Is condition: Congenital: Chronic: Recurrent: (Indicate where applicable)

Is condition work related or occupation illness/injury? Please explain.

Date when the condition was first diagnosed?: D D M M Y Y Y Y

Date of previous treatment for this illness/injury?: D D M M Y Y Y Y

Date of current treatment?: D D M M Y Y Y Y

Any underlying conditions which could result to this illness/injury?:

Was patient referred to a specialist?: (Y) (N)

Indicate specialist services & specialist name:

(Please attach all receipts/invoices and copies of prescriptions relating to this claim including chemist bills - otherwise the bill will not be settled).

Treatment given: Consultation Laboratory Dental/Optical Drugs

Total cost of treatment

(For reimbursement claims, please complete the bank details form available from your HR)

MEMBER'S DECLARATION & CONSENT

I hereby confirm that all particulars stated above are true and complete. No information has been omitted. I authorise the provider of service(s) to disclose the required medical information to include the nature of my illness and that of my dependants to Aon for its confidential use.

Signed: Date:

DOCTOR'S CERTIFICATE

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

Name: Qualifications: Signed:

Stamped: Date:

FOR OFFICIAL USE ONLY

Amount payable KShs.:

Minet Kenya Insurance Brokers Ltd, Minet House,Off Nyerere road | P. O. Box 48279 - 00100 Nairobi, Kenya
(t) +254 (0) 20 4974444/0719044444 (f) 2721825 | (e) casemanagement@minet.co.ke www.minet.co.ke