UAP OLDMUTUAL

OUT-PATIENT CLAIM FORM

Practitioners Name ______________________ **Practitioner's Official Stamp**

Postal Address ______________________

Tel No. ____________ Mobile ____________

Email ______________________

PATIENT'S PARTICULARS

Full Name of Patient______________________ Date of Birth ____________

Full Name of Member (if patient is a dependant) ______________________

Member's Tel No. ______________________ Member No.____________

Member's Employer Name ______________________ Dept. /Branch ____________

Have you suffered from this sickness in the past? YES ☐ NO ☐

If YES, when did it start and how frequent is it? ______________________

CONSULTATION/REFERRALS

DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription	☐	Injection given	☐	Dispensed	☐	None	☐
RADIOLOGY:	X-Ray	☐	MRI/Cat Scan	☐	Other	☐	Other	☐
PATHOLOGY:	Haemotology	☐	Microbiology	☐	Biochemistry	☐	Histology	☐

Hospital Name: ____________ Consultant Referred To: ____________ Specialty: ____________

MEDICATION PRESCRIBED:

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Dr's Signature ______________________ **Date** ____________

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature ______________________ **Date** ____________

UAP Insurance Company Limited
UAP Old Mutual Tower, Upperhill Road. P.O Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000
Email: health@uap-group.com Website: www.uapoldmutual.com

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