ASKARI GENERAL INSURANCE COMPANY LIMITED

HEALTH
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ISO 9001:2008 CERTIFIED

CLAIM FORM

(For Medical Reimbursement of Claims)

Organization Name ______________________ Branch ____________
Employee Name ______________________ Folio No. ____________
Designation ____________ Patient's Name & CNIC ______________________
Patient's Age ____________ Relation with Employee ____________ Sex (M / F) ____________

CLAIM DETAILS

Name of the Doctor ______________________ Hospital/Clinic ______________________
Address ______________________
Doctor's Contact Number ____________ Doctor sign/stamp and valid PMDC Number ____________
Date of Visit ____________ Consultation Fee (Rs.) ____________ Cost of Medicine (Rs.) ____________
Name & Cost of Investigation / Lab. Test (Rs.) ____________ Total Cost (Rs.) ____________

NATURE OF CLAIM: (Tick relevant) OPD/ HOSPITALIZATION/ MATERNITY/DREAD DISEASE/SPECIALIZED INVESTIGATION

DOCUMENTS CHECKLIST: PLEASE ATTACH THE FOLLOWING AND TICK TO REMEMBER. PHOTOCOPIES ARE NOT ACCEPTABLE FOR PAYMENT.

- ☐ ORIGINAL PRESCRIPTION ON DOCTOR'S LETTERHEAD.
- ☐ FRESH PRESCRIPTION EVERY 3-6 MONTHS IN CASE OF DIABETES, HYRERTENSION, HEPATITIS TREATMENT. PHOTOCOPY ACCEPTABLE FOR INBETWEEN REFILLS.
- ☐ ORIGINAL CONSULTATION FEE RECEIPT.
- ☐ ORIGINAL MEDICAL STORE CASH MEMO WITH LICENCE NUMBER.
- ☐ VALID DR. PMDC NUMBER IS MANDATORY IN CASE OF NON-PANEL.
- ☐ ORIGINAL DISCHARGE CARD.
- ☐ BIRTH CERTIFICATE ISSUED BY NADRA OR UNION COUNCIL.
- ☐ DR. ADVICE FOR MEDICINES, TESTS/ INVESTIGATIONS AND THEIR REPORTS.
- ☐ IN CASE OF MISSING DOCUMENTS OR WRONG TOTALLING, THE CLAIM WILL BE RETURNED BACK.
- ☐ CLAIMS OLDER THAN 90 DAYS ARE TIME BARRED AND MAY NEED SPECIAL APPROVAL.

CERTIFIED THAT ABOVE ENTERED INFORMATION IS TRUE AND ACCURATE. IF FOUND FRAUDULENT, INCOMPLETE OR INFLATED, I WILL BE RESPONSIBLE.

EMPLOYEE'S SIGNATURE ____________ BANK & ACCOUNT NO. (ONLY FOR EFT CLIENTS) ____________

FORWARDED BY (HR): ______________________ Date: ____________