



REIMBURSEMENT CLAIM FORM

To be filled by the Patient / Physician:

Employee Name:	Ref No:
Card Number:	Contact No:
Date of Service:	Cheque to be drawn to:
Name of the Provider:	Type of Claim (Local/International):
Amount Claimed:	Date of Submission:

To be filled by the Physician:

Chief Complaint / Symptoms:					
Date of Present Onset:			Diagnosis / Diagnosis Code:		
Chronic <input type="checkbox"/>	Acute <input type="checkbox"/>	Congenital Condition <input type="checkbox"/>	Work Related <input type="checkbox"/>		
Clinical Findings:	BP:	Temp:	HR:	RR:	PR:
<ul style="list-style-type: none"> • Physical Findings: • Investigations Done: • Treatment Done: 					
<p>I declare that I am the patient's Medical Practitioner and the particulars given are to the best of my knowledge true and correct.</p>					
Name of the Physician:		Date:		SIGNATURE & STAMP	
<p>I hereby authorize any Healthcare provider, Insurer to release any information regarding my medical condition & history to Pentacare for the purpose of determining insurance benefits.</p>					
Patient's Name & Signature:				Date:	

- ❖ All documents should be translated in English, before submission.
- ❖ Please retain copies of all documents submitted to us for future reference.
- ❖ In case of any additional documents requirement, we will contact you on receipt of your claim documents by us.
- ❖ Reimbursement claims submission period will be as per policy terms and conditions.
- ❖ For any further clarifications, you may contact us at reimbursement@pentacare.net or call 04-2946443 during office hours.