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 ☐ Acute ☐ Congenital Condition ☐ Work Related ☐					
Clinical Findings:	BP:	Temp:	HR:	RR:	PR:

- Physical Findings:
- Investigations Done:
- Treatment Done:

I declare that I am the patient's Medical Practitioner and the particulars given are to the best of my knowledge true and correct.

Name of the Physician: **Date:** **SIGNATURE & STAMP**

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.

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.