STATE LIFE

INSURANCE CORPORATION OF PAKISTAN

FORM NO: [H102]
CLAIM REIMBURSEMENT FORM

HEALTH INSURANCE CLAIM REIMBURSEMENT FORM

Type of Claim ☐ Pre-Hospitalization Expense ☐ Hospitalization/Daycare Expense ☐ Post-Hospitalization Expense ☐ OPD
☐ Pre-natal Expense ☐ Maternity Expense ☐ Post-Natal Expense

Claimant Name:	Patient Name:
Employer Name:	Contact Number:
CNIC: ☐☐☐☐☐–☐☐☐☐☐☐☐–☐	Health Card No: ☐☐–☐☐☐☐–☐☐☐☐☐

Details of Medical Expenses-Inpatient

Title of Expense	No. of Receipts Attached	Amount Claimed
Inpatient-non-maternity		
Inpatient-maternity		
ER Treatment		
Day Care		
Special Investigations		
Other _____		
Total		

List of Required documents for Inpatient treatment:
- ☐ Copy of health card
- ☐ Copy of CNIC
- ☐ Discharge Summary
- ☐ Original Receipts
- ☐ OT Notes (If applicable)
- ☐ Any other Documents please mention:

1. _____ 2. _____

Details of Medical Expenses-Outpatient

Title of Expense	No. of Receipts Attached	Amount Claimed
Consultation		
Medicine		
Investigations		
Other _____		
Total		

List of Required documents for Inpatient treatment:
- ☐ Original Prescription
- ☐ Original Reports
- ☐ Pharmacy Receipts (For medicine reimbursement)
- ☐ Original Receipts of Investigations
- ☐ Any other Documents please mention:

1. _____ 2. _____

Bank Account Details:

Total Amount Claimed in Rs.: _____

Account Title:	Bank Name:
IBAN: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐	

DECLARATION

I/We hereby confirms that the information provided in the form and the documents attached are true and complete to the best of my knowledge.

Date
☐☐ ☐☐ ☐☐

Signature/Stamp
_____

IMPORTANT: In order to avoid delay, please ensure that

- The form is filled correctly and submitted along with all documentary evidence
- Account details are correct
- Original documents are attached
- Claims are submitted within 30 Days of availing IPD/OPD services