ISO 9001:2008
CERTIFIED

ASKARI GENERAL INSURANCE COMPANY LIMITED
HEALTH
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CLAIM FORM

(For Medical Reimbursement Claims)

Organization Name _____
Employee Name_____ _____Folio No._____
Designation _____Patient`s Name&CNIC_____
Patient`s Age _____Relation with Employee _____ Sex (M / F) _____ _____

EMPLOYEE CONTACT No. ---------- (for CLAIM PROCESSING UPDATES)

CLAIM DETAILS

Name of Clinic / Hospital and Doctor _____
Date of Visit_____Consultation Fee (Rs.) _____Cost of Medicine (Rs.) __
Name & Cost of Investigation / Lab. Test (Rs.)_____Total Cost (Rs.) _____
Doctor sign/stamp and valid PMDC Number: _____ (TO BE FILLED BY TREATING DOCTOR)

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: ___