ATLAS INSURANCE LIMITED

HEALTH INSURANCE CLAIM FORM

SECTION A-TO BE COMPLETED BY THE CARD HOLDER

Organization Name: _____Health Card #: _____

Employee Name:_____ Designation: _____

Current Office Address: _____

Contact No:_____ Patient Name: _____ Patient Age:_____

CNIC No: _____ Relation with Employee: _____Sex(M/F): _____

CLAIM DETAILS

Name of Clinic/Hospital and Doctor: _____

Date of Visit: _____ Date of Admission (Inpatient): From _____ To _____

Consultation Fee(Rs): _____ Cost of Medicine(Rs) :_____

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 BILLS/RECEIPTS ARE NOT ACCEPTABLE FOR PAYMENT:

- ORIGINAL PRESCRIPTION ON DOCTOR'S LETTERHEAD.
- FRESH PRESCRIPTION EVERY 6 MONTHS IN CASE OF DIABETES, HYRERTENSION, HEPATITIS TREATMENT. PHOTOCOPY ACCEPTABLE FOR INBETWEEN REFILLS.
- ORIGINAL CONSULTATION FEE RECEIPT.
- ORIGINAL MEDICAL STORE CASH MEMO.
- ORIGINAL DISCHARGE CARD.
- DR. ADVICE FOR MEDICINES, TESTS/ INVESTIGATIONS AND THEIR REPORTS.
- IN CASE OF MISSING DOCUMENTS OR WRONG TOTALLING, THE CLAIM WILL BE RETURNED BACK/OBJECTION WILL BE COMMUNICATED.
- 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 SIGNATURE: _____ Date: _____

FORWARDED BY (EMPLOYEE HR): _____ Date: _____

SECTION B-TO BE COMPLETED BY THE TREATING PHYSICIAN

1.	On what date were you first consulted for the injury, illness or medical condition concerned, on for any related condition?	
2.	Please give your diagnosis of the injury / illness / condition:	
3.	If an accident is involved, how did it happen?	
4.	Please give details of the treatment given or prescribed:	

Please Write your Name:		Address:	
Signature of treating physician Date:		Physician's Rubber Stamp	