Aafiya
Managing your care process

# MEDICAL CLAIM FORM

| Provider Name: | Patient Name: | |
|---|---|---|
| Insurance Company: | Patient Contact No: | File No: |
| Company Name: | Member ID: | |
| Date Of Treatment: (dd/mm/yyyy) | Date Of Birth: (dd/mm/yyyy) | Gender: |

| Chief Complaints: | | | |
|---|---|---|---|
| Referral (if needed): | | | |
| Clinical Findings: BP: TEMP: HR: RR: | | | |
| Diagnosis: | Diagnosis Code: | Date of Onset : (dd/mm/yyyy) | |
| PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED ☐ OTHERS ☐ | | | |

| Treatment Plan: | | | |
|---|---|---|---|
| Requested Investigations: | | | Estimated Cost: |
| Prescription: | Dose: | Duration: | Estimated Cost: |

| **MEDICAL PRACTITIONER DECLARATION:** | **PATIENT'S DECLARATION:** |
|---|---|
| *I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.* | *I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining insurance benefits.* |
| *Dr's Name:* *Stamp:* | |
| *Signature:* *Date:* | *Patient 's signature{Parent if minor} :* *Date:* |