e-care International

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MEDICAL CLAIM FORM

(Please Fill Clearly)

Form No. EC 76001

ADMIN. SECTION:

INSURANCE INFORMATION:

Policy No: .....

Policy Expiry : _____ / _____ / _____
dd mm yy

Company Name: .....

UB No. .....

PATIENT INFORMATION:

Patient Name: .....

Date of Birth: _____ / _____ / _____ Gender : M F
dd mm yy

Mobile No: .....

Provider Name:.....

MEDICAL SECTION:

Illness / Injury: (please mark one) ☐ Acute ☐ Chronic ☐ Emergency ☐ Work Related

Diagnosis: .....

.....

Patient Conditions: .....

.....

Investigation Required: (I).....

(II).....

(III).....

Estimated Cost:
Dhs.....

.....

Lab Investigations: (For Network Labs only) (I).....

(II).....

(III).....

Estimated Cost:
Dhs.....

.....

PHARMACEUTICAL:

	Cost
(I).....	
(II).....	
(III).....	

PRE-AUTHORIZATION: (FOR E-CARE USE ONLY)

Remarks on purposed request:

.....

.....

Total approved Cost: DH:.....

As per Policy

☐ Approved ☐ Not Approved

Ref No: .....

E-Care Stamp & Date: .....

Declaration:

We declare that all the above given information and purposed treatment is genuine and liable for any misuse of services.

..... Doctor's Sign & Stamp

_____ / _____ / _____
dd mm yy
Date

..... Patient Signature

White copy: E-Care – **Yellow copy:** Pharmacy – **Pink copy:** Diagnostic Centre / Lab