REIMBURSEMENT CLAIMS FORM

To be filled by the patient / Physician

PROVIDER NAME:	PATIENT NAME:
Date of Treatment:	Member Insurance ID:
DOB :	Patient Tel:
Patient Address:	

To be filled by the Physician

CHIEF COMPLAINT / SYMPTOMS:					
Date of present onset:			Diagnosis: Diagnosis Code:		
Chronic ☐	Acute ☐	Congenital Condition ☐			
Clinical Findings :	B.P	Temp:	HR:	RR:	PR:
Physical Findings:					
Details of any investigations Done :					
Details of the Treatment Done :					

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.

Name of the Physician:

Signature **Date** **STAMP**

I hereby authorize any Healthcare provider, Insurer to release any information regarding my medical condition & history to Pentacare for the purpose of determining insurance benefits.

Patient's Name & Signature: Date:

* Attach all the original invoices, investigation results and medical report, Discharge summary (if Inpatient) along with this form for claims reimbursement subject to policy terms & conditions

Pentacare Contact Information: **TEL: 04-2946443 FAX: 04 - 2946448**