UAP

Better. Simple. Life.

CLAIM FORM
(Out-Patient)

Practitioners Name _____ Practitioners Official Stamp

_____

Postal Address _____

_____

Tel _____ Mobile _____

Fax _____

PATIENT'S PARTICULARS

Full Name of Patient _____ Date of Birth _____

Full Name of Member (if patient is a dependant) _____

Policy No. _____ Member No. _____

Member's Employer Name _____ Dept/Branch _____

_____

1) Have you suffered from this sickness in the past? YES ☐ NO ☐

If YES, when did it start and how frequent is it? _____

CONSULTATION/REFERRALS

DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription ☐	Injection given ☐	Dispensed ☐	None ☐
RADIOLOGY:	X-Ray ☐	MRI/Cat Scan ☐	Other ☐	Other ☐
PATHOLOGY:	Haemotology ☐	Microbiology ☐	Biochemistry ☐	Histology ☐

HOSPITAL NAME:	CONSULTANT REFERRED TO:	SPECIALITY:

MEDICATION PRESCRIBED

_____

_____

Dr's Signature _____ Date _____

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature _____ Date _____

UAP Insurance Company Limited
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