

Claim Form

IMPORTANT INSTRUCTIONS: (please read them first)

- I- In order for us to provide fast and efficient service, please complete the Form accurately in 'CAPITAL LETTERS'. Photocopies of this form can also be used.
- II- Filled forms should be sent to: Claims Department, Allianz EFU Health Insurance, D-136 , Block-4, K.D.A, Scheme #5 Clifton, Karachi within 30 days of the expense incurred date. Please attach the following with the form:
- Proper itemized bill(s) and payment receipt(s) as highlighted below. These should be issued on the official bill/receipt book of the Hospital/Physician/Surgeon/Pharmacy/Laboratory.
 Proper hospital bill in original highlighting type of accommodation used (room type) and break up of total bill according to:
 ❶ Room charges ❷ Lab tests and Radiology Charges ❸ Consultation charges ❹ Surgeons fee with details (if any)
 ❺ Operation Theatre Charges (if any) ❻ Anesthesia charges (if any) ❼ Medicines (used during hospitalization)
 ❽ Other miscellaneous medical expenses like blood & oxygen, etc.
 - Laboratory, or Radiology reports along with doctor's reference for the same.
 - Itemized bill(s) of medicines purchased supported by Physician's prescription specifying the quantity and respective dosage.
 - Hospital discharge summary / Clinical Summary (in case of Hospitalization).
 - Copy of Birth Certificate (in case of delivery/child birth)
- III- If you have any difficulties filling this form, please call our Claims Dept. at **111-HEALTH** (021-111-432584)
 Approved claim could be settled through direct bank transfer. Please provide following bank details for direct bank transfer.

To Be Completed by the Employee / Policy Holder:

Name of the Policy Holder:	<input type="text"/>	Policy Number:	<input type="text"/>
Name of the Employee:	<input type="text"/>	Cert. Id:	<input type="text"/>
Name of Patient:	<input type="text"/>	Total Amount Claimed:	Rs. <input type="text"/>
Date of Birth:	<input type="text"/>	Relationship to the Employee:	<input type="text"/>
Exact duration of illness/injury claimed for:	<input type="text"/>		
Bank:	<input type="text"/>	NIC Number (if any):	<input type="text"/>
Branch:	<input type="text"/>	Department:	<input type="text"/>
A/C. No:	<input type="text"/>	Contact No:	<input type="text"/>
		Email :	<input type="text"/>

Any history of the same/similar illness or treatment in the past? Yes No (if yes, please complete the following)

Name of Patient	Nature of illness / Disability & Treatment Received	Preiod of Disability / Treatment			Remarks
		Month	Year	Duration	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

In case of Hospitalization:

Emergency Treatment or Elective?	<input type="text"/>	Was pre-authorization taken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Admission:	<input type="text"/>	Date of Discharge:	<input type="text"/>

Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so name the companies or association, or other source, and give amount of benefit payable by each:

<input type="text"/>

Declaration / Authorization:

I hereby certify that all answers, and all documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any company, institution or any other person who has any record or information about me and/or of my family members to provide Allianz EFU Health Insurance Limited with the information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this declaration/authorization shall be taken as the original copy.

Signature of Patient

(if 18 years or above, otherwise signature of the employer)

Signature & Seal of the Employer

(For Corporate Schemes only)

Date

To Be Completed by the Attending Physician/Hospital:

Patient Name:

Primary Diagnosis: Secondary Dignosis:

When did the symptoms first appear? Day Month Year

Are you the patient's primary physician: Yes No

When did the patient first consult you for this complain? Day Month Year

Has the patient ever suffered from/been treated for the same OR related condition? If yes, please provide details with dates:

In case of Hospitalization:

Name & Address of the Hospital:

Phone Number: Fax Number:

Hospital Admission Date: Discharge Date:

Emergency Treatment or Elective?

Details of Surgical, Gynecological or Obstetrical procedure performed, (if any):

Type of Anesthesia Used (regional/general):

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief.

Signature & Stamp of the Attending Physician:

Name & Address:

Phone Number: Fax #

Credentials/Qualifications: Date:

For Allianz EFU Health Insurance Use Only

Policy Number: Certificate Number:

Claim Number: Authorization Number

Claim Received On: Claim Entered By:

Claim Approved By: Claim Cheque Dispatched On: