

# REIMBURSEMENT CLAIM FORM



Please Complete Clearly (All Fields Mandatory)

FORM No:

## ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		
Date of Service: dd / mm / yyyy	Patient's Tel:	DOB: dd / mm / yyyy	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Card No (Mandatory):	Patient's Employer:		

## SUBJECTIVE (To be completed by Physician)

Symptom(s) As Described by Patient (CHIEF COMPLAINT)

Date of Present Symptom Onset: dd / mm / yyyy

What date did the Patient first feel same / similar Symptom(s): dd / mm / yyyy

Is the Patient under any type of Treatment  Yes  No if yes, Indicate what Assessment and since when:

## OBJECTIVE/ASSESSMENT (To be completed by Physician)

Clinical Findings: Vital Signs: B/P: \_\_\_\_\_ T: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_

Cause:  Physical Illness  Accident  Maternity  Preventive  Dental  Work Related  Other

Assessment/Diagnosis:  Acute  Chronic  Confirmed  Suspected **DIAGNOSIS CODE**  
INDICATE DIAGNOSIS NOT SYMPTOM

1.

2.

3.

Is Assessment/ Diagnosis related to another Assessment?  Yes  No if yes, Specify: (i.e. Retinopathy related to Diabetes)

## MEDICAL PLAN (Itemized Original Invoice and Application Prescriptions/ Reports /Results must be enclosed to consider claim.)

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory/Radiology/Other	Cost

## TOTAL CHARGES

Was In-Patient Required? Length of stay \_\_\_\_\_ Indicate Provider \_\_\_\_\_ Cost \_\_\_\_\_

\*Discharge Summary , Itemized Invoices, Reports & Receipts Attached ?

Treating Physician Name \_\_\_\_\_

Tel/Fax \_\_\_\_\_

Signature/Stamp \_\_\_\_\_

I hereby authorize any Healthcare Provider, TPA, Employer or other organization to release any information regarding my medical condition & history to UIC for the purpose of determining insurance benefits.

Patient's Signature(Parent if Minor) \_\_\_\_\_ Date dd / mm / yyyy