2. CLAIM FORM FOR OUT PATIENT TREATMENT

Section A. To be completed by the insured member.
To proceed with the examination of your Claim, the original receipts and test results should be submitted

INSURANCE COMPANY	**GAN DIRECT INSURANCE LTD**
NAME AND SURNAME	
DATE OF BIRTH	
POLICY NUMBER	

DECLARATION AND CONSENT: I hereby responsibly declare that all, without exception, the information given in this form, are true and complete. I authorize the company or any Authorized Company for Claims Handling to get any information and reports in respect of my physical and mental health from any person or institution. I also give my consent to share this information with other organizations for the settlement of this claim

Signature of the insured………………………………………….…………….ID No……………………………

Section B. To be completed by the treating doctor

Name of Patient:…………………………………………………………………….Age:………..……..…

Symptoms:………

……………………………………………………………………………………..………………………………...

Onset of Symptoms:…………………………………………………………………………………..……………..

Dates of previous consultations:…………………………………………………………………………………….

Diagnosis:………

………..

Treatment: Conservative…………………………..Surgical……………………………………………………………

Diagnostic Tests:……………………………………………………………………………………………………

………

Medication:………

………

………..

DOCTOR'S NAME:…………………………………………..

DATE:……………………………………….

SIGNATURE AND SEAL

<u>Warning: All supporting documentation (originals) must be provided along with the claim form</u>

<u>Supporting Documentation for out-patient treatment</u>

1. Claim Forms (Fully completed)
2. Doctor's fees/ receipts
3. General Practitioner's reference (If applicable)
4. Post Surgical Physiotherapy fees (If applicable)
5. Diagnostic/ Laboratory tests/ analysis's outcomes (If applicable)
6. Medicines invoices/ receipts
7. Invoices/ Receipts for Laboratory tests/ analysis's outcomes (If applicable)
8. Ambulance charge (If applicable)
9. Payment settlement
10. Discharge note
11. Medical history/ Doctors reports
12. Medicines Card
13. Vitals Card
14. Medical & Nursing instructions card
15. Doctor's or Outpatients department's reference (If applicable)
16. M.R.I. (If applicable)
17. X-RAYS (If applicable)
18. E.C.G. (If applicable)
19. CT SCANS (If applicable)
20. Physiotherapy (If applicable)
21. Hospital/ Clinic/ Doctors invoices
22. Affirmation of contribution by any Fund or Organization (If applicable)
23. Receipts of payments (If applicable)