MEDICAL POLICY CLAIM FORM

UMMA INSURANCE BROKERS
Head Office:
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DIRECTIONS:
Please read carefully and fill out the entire form in BLOCK LETTERS.
1. *Complete a separate claim form for each insured individual and for each visit to the doctor or service provider.*
2. *Attach ALL medical bill(s) relating to the claim.*
   a. *Make certain, all bills identify the respective patient.*
   b. *All bills should indicate date of treatment, description of service & charges.*
3. *Date and sign the form and ensure that the same is signed and stamped by the Doctor/Provider in the space provided.*
4. *No claim will be considered if submitted after 90 days from the date of illness.*
5. *Providers are advised to cross check the medical card against the national ID card for adult patients to ensure that member details are correct.*
6. *All invoices must be signed by the client.*

EMPLOYEE (MEMBER) INFORMATION *(This is the individual whose name is on the ID card)*

Scheme

Name *First Name* *Middle Name* *Surname* ID No.

Member No. Mobile *PLEASE PROVIDE A MOBILE MONEY ENABLED NUMBER FOR REIMBURSEMENTS E.G. M-PESA, AIRTEL MONEY*

P. O. Box *Postal Code* Email

PATIENT INFORMATION

Patient Name *First Name* *Middle Name* *Surname* Member No.

Date of Birth *dd/mm/yyyy* Sex: Male ☐ Female ☐ Relationship: Employee ☐ Spouse ☐ Child ☐

AUTHORISATION FOR RELEASE OF INFORMATION *(Patient, parent or guardian must sign below)*

I hereby warrant the truth of the above statements, that I have not withheld from Umma insurance Brokers any information relating to this claim. I have no objection to the medical underwriter and/or their representatives communicating with the Doctor/Physician or Hospital I have consulted or visited and shall submit to any medical examination(s) if so required by Umma Insurance Brokers.

Signature of patient, parent or guardian (if patient is a minor) _____ Date _____

MEDICAL INFORMATION *(To be completed by the Doctor/Physician treating the patient)*

What is the diagnosis for the patient? (Write in BLOCK LETTERS, No Medical Shorthand)

Is this condition: recurrent? ☐ chronic? ☐ congenital? ☐

Date(s) of previous treatment for this illness or injury 1. *dd/mm/yyyy* 2. *dd/mm/yyyy* 3. *dd/mm/yyyy*

Any underlying conditions which could result in this illness or injury?

Nature of treatment

Was the patient referred to a specialist? Yes ☐ No ☐

If yes, provide details of the specialist or in case of accidental injury, provide details

CERTIFICATION BY MEDICAL PRACTITIONER

I certify that the above information regarding Mr/Mrs/Mst/Ms. _____
is true, to the best of my knowledge and the expenses incurred are as a result of the accident/illness referred to.

Name and address of Doctor/Physician _____

Qualifications _____

Date _____ Signature and Official Stamp _____

**** Incomplete forms shall not be processed.***