Aafiya
Managing your care process

MEDICAL CLAIM FORM

Provider Name:	**Patient Name:**	
Insurance Company:	**Patient Mobile No:**	File No:
Company Name:	**Member ID:**	
Date Of Treatment: **(dd/mm/yyyy)**	Date Of Birth: (dd/mm/yyyy)	Gender:

Chief Complaints:			
Referral (if needed):			
Clinical Findings: BP: TEMP: HR: RR:			
Diagnosis:	Diagnosis Code:	**Date of Onset :** (dd/mm/yyyy)	

PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED ☐ OTHERS ☐

Treatment Plan:			
Requested Investigations:			Estimated Cost:
Prescription:	**Dose:**	**Duration:**	Estimated Cost:

MEDICAL PRACTITIONER DECLARATION:	**PATIENT'S DECLARATION:**
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct. *Dr's Name:* *Stamp:* *Signature:* *Date:*	*I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining insurance benefits.* *Patient 's signature{Parent if minor} :* *Date:*