

SECTION A: MEDICAL PROVIDER DETAILS

Provider Name Provider License No

SECTION B: PATIENT DETAILS

Patient Name (as per card) Patient Mobile No
Card Number Patient File # Patient DOB

SECTION C: CLAIM DETAILS

To be completed by attending Physician

Please tick: Outpatient Inpatient Emergency? Yes No

Pre-Authorisation No (if applicable)

Chief Complaint and Symptoms

What date did the patient first feel same/similar symptoms?

Significant Signs

Other Conditions

Date of this visit:

Diagnosis

MANDATORY: ICD Code (please tick) ICD9 ICD10 (See Amity Reference Guide)

Principal Code 2nd Code 3rd Code 4th Code

Please tick where appropriate

Congenital Chronic RTA Psychiatric Others (please specify) _____
 Check-up Acute Infertility Work-related Vaccination Pregnancy/Indicate LMP: _____

SECTION D: PROPOSED MEDICAL MANAGEMENT PLAN

Suggestive line(s) of management: Kindly list the recommended investigations and/or procedures

CODE	TYPE OF CODE USED	DESCRIPTION / SERVICE	QUANTITY	TYPE	COST

Anticipated Management Plan: TOTAL COST

Referral Doctor's Name (if patient has been referred) License No

PATIENT DECLARATION

I declare that I am the patient, patient's parent or guardian (if patient is under 16 years of age) and that all information provided in the claim form is to the best of my knowledge true and correct. This declaration gives Amity the permission to get all information about my claim including, but not limited to, my current medical and previous medical providers/physician, pharmacy or any other person who has provided medical services to me or my dependants. I agree that a copy of this consent shall have the validity of the original.

Signature Date

MEDICAL PRACTITIONER DECLARATION

I declare that all information mentioned is correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Name Tel/Fax Signature and Stamp
License No Date