

REIMBURSEMENT MEDICAL CLAIM FORM

1.	Insured Member:	••••	EDP/	FNPF no:
2.	Employer:		Secto	r:
	Email		Conta	act phone no:
3.	Name of Patient:	M/F.		DOB
4.	Name of Physician:			
5.	Date Treated:		Time	Treated:
6.	Diagnosis:			
7.	Cost Incurred: ORIGINAL RECEIP Doctor's Fee: \$ P X-Ray & Lab: \$ S Other Expenses: \$ TOTAL AMOUNT PAID \$	Pharmacy Specialis	y Bills: t Fee:	\$ \$
Bank A	Account Code:			
Bank 1	Account Number:			
	Name:			
Bank l	Name:			
Bank I Brance Insure It is ma will res	Name: h: d Members Signature: ndatory requirement by Bank that where payment is rult in having \$1.00 deducted from the claim payment	rejected d	Date:	correct bank details provided
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