



REIMBURSEMENT MEDICAL CLAIM FORM

1. Insured Member: EDP/FNPF no:
2. Employer: Sector:
Email..... Contact phone no:
3. Name of Patient: M/F DOB
4. Name of Physician:
5. Date Treated: Time Treated:
6. Diagnosis:
7. Cost Incurred: **ORIGINAL RECEIPTS ATTACHED**
Doctor's Fee: \$ _____ Pharmacy Bills: \$ _____
X-Ray & Lab: \$ _____ Specialist Fee: \$ _____
Other Expenses: \$ _____
TOTAL AMOUNT PAID \$ _____

Bank Account Code: _____

Bank Account Number: _____

Bank Name: _____

Branch: _____

Insured Members Signature: _____ **Date:** _____

It is mandatory requirement by Bank that where payment is rejected due to incorrect bank details provided will result in having \$1.00 deducted from the claim payment as a fee for reloading.

IMPORTANT:

To ensure speedy handling of your claim please go thru this list and ensure everything that is required has been submitted with this Claim Form to FijiCare Insurance.

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|--|-----|----|
| i) Have you filled in Diagnosis in No. 6? | Yes | No |
| ii) Are all Original Receipts Attached? | Yes | No |
| iii) Specialist Referral: Have you attached copy of referral from your Doctor? | Yes | No |
| iv) X-Rays & Lab Referral: Have you attached copy of referral letter from your Doctor? | Yes | No |
| v) Optical & Dental Reimbursements: Have you obtained breakdown of Expenses? | Yes | No |
| vi) Have you attached Medical Report? | Yes | No |