



REIMBURSEMENT MEDICAL CLAIM FORM

- 1. Insured Member: EDP/FNPF no:
 - 2. Employer: Sector:
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. Charges: \$ _____
 - Specialist Fee: \$ _____
 - Other Expenses: \$ _____
 - _____
 - _____
- TOTAL AMOUNT PAID \$ _____

Insured Members Signature:

Date:

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.

- 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