Head Office: 5-Saint Mary Park, Gulberg III, Lahore-Pakistan
Alfalah Customer Care: +92 042-111-234-222 Fax: +92 042-35774329, 35774330
Email: approvals@alfalahinsurance.com

OPD CLAIM FORM (TO BE FILLED BY EMPLOYEE)

1	NAME OF THE POLICY HOLDER					
2	BRANCH & CITY					
3	NAME OF EMPLOYEE					
4	EMPLOYEE#		PLAN			
5	EMAIL ID		CONTACT NO.			
6	NAME OF PATIENT		AGE (In Years)			
7	RELATION WITH EMPLOYEE (encircle the right choice)		SELF	SPOUSE	DAUGHTER	SON
8	DIAGNOSIS					
9	TREATMENT DATES / MONTH					
	DETAILS OF AMOUNT CLAIMED					
	DATE / TREATMENT DETAIL / INVOICE #				**AMOUNT IN RS.**	
(i)						
(ii)						
(iii)						
	TOTAL AMOUNT CLAIMED					

CHECKLIST:

- Please submitt monthly OPD bills with a single Claim Form for a single patient.
- Use separate Claim Forms if bills are for more than one patients / persons.
- Please ensure to attach the following documents along with this claim form. **(***Please indicate by tick mark* ***yourself)***

Sr#	DOCUMENTS	YES	NO	If "NO" Then Describe the Reason
(i)	Copy of the Prescription of the doctor			
(ii)	Original Invoices of the doctor & lab etc			
(iii)	Original Pharmacy Invoices			
(iv)	Copy of Reports of the investigations claimed			
(v)	Copy of CNIC and Health Card			

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim.

_____
Employee's Signature with date

_____
HRD – Bank Alfalah Limited

FOR COMPANY'S USE ONLY:

CLAIM DUE TO	CONSULTATION	PHARMACY	INVESTIGATIONS	DENTAL	OTHER (SPECIFY)
	Rs.	Rs.	Rs.	Rs.	Rs.
Any Deduction	Rs.		**Amount Approved**		**Rs.**
Remarks / Reason of Deduction			Final Diagnosis		
Claim Processed By:			Claim Approved By:		