Alfalah Insurance

OPD CLAIM FORM (TO BE FILLED BY EMPLOYEE)

1	NAME OF THE POLICY HOLDER					
2	BRANCH & CITY					
3	NAME OF EMPLOYEE					
4	EMPLOYEMENT ID		PLAN			
5	NAME OF PATIENT		AGE (In Years)			
6	RELATION WITH EMPLOYEE (encircle the right choice)		Self	Spouse	Daughter	Son
7	DIAGNOSIS					
8	TREATMENT DATE (DD/MM/YY)					
	DETAILS OF AMOUNT CLAIMED					
	INVOICE #:		**AMOUNT IN RS.**			
(i)						
(ii)						
(iii)						
(iv)						
	TOTAL AMOUNT CLAIMED					

CHECKLIST:

- 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)	Prescription of the doctor			
(ii)	Original Invoices of the doctor & lab etc			
(iii)	Computerized Pharmacy Invoices			
(iv)	Copy of Investigation's Reports			

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. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution.

_____
Employee's Signature with date

_____
Department Head/Branch
Manager's Signature & Stamp

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:	