Alfalah Insurance

INTIMATION FORM

Hospital Name:*	**To :** **ALFALAH INSURANCE - HEALTH DEPARTMENT**
Email: **Hospital Contact person name:** **Phone No:***	**UAN :** 111-786-234 **Hot Line Numbers:** 0321-4041555, 0322-4041555 **Email:** approvals@alfalahinsurance.com **Fax Number:** 0425774329-30
Hospital Medical Record #	**Patient Contact #***
Claim Number:	**Enhancement Details:**

Patient Details*	**Patient`s Name:**	**AGE:**
	Relation with employee :	**NIC #**
Policy Holder Details*	**Company :**	**Employee Name:**
	Policy No :	**Health Card/Letter ID #**
Date/Time of Admission*	**Date :** **Time:**	**Room/ICU/Ward #:**
Reason for Admission* (presenting complaints)		
Provisional Diagnosis*		
Consultant Name* (Panel/Visiting)		
Treatment Details*		
Procedure Details	**Surgery** **Specialized Investigations** **Lab Investigations**	
Room/Ward Charges per day	**Rs.**	**Expected Length of Stay:**
Estimated Bill (RS.)*		

Note: Fields marked with * are mandatory to be filled.

Signed for and on behalf of:

Patient/Guardian……..

Left Thumb Impression of the patient……

Signed for and on behalf of Hospital

Signature…….....

Name……