MEDICAL AID CLAIM FORM

prabhu INSURANCE®

protecting your future.

Prabhu Insurance Limited

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Medical Aid Scheme for the Employees of .....

Claim No. .....

This form is issued without admission of liability and should be completed and returned to **Prabhu Insurance Limited Kathmandu** as soon as possible and in any event within 60 days of the commencement of the illness or the date of the accident.

1. **Member :**

   Name of the patient..... Date of Birth .....

   Home Address .....

   Office Address .....

   Designation/Relationship of employee .....

   Sex .....

2. **If Injured in an Accident :**

   Date and time of Accident .....

   Where did it occur .....

   Details of cause .....

   Injuries Sustained .....

3. **If an Illness :**

   Details of illnes :.....

   .....

   .....

   .....

   .....

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   .....

   Date of incapacity or dingnosis .....

4. **Medical Attendants :**

   Name and Address of Private Doctor :.....

   Attending Member .....

   Name and Address of all Surgeons,.....

   Anasesthetist, Secialists, Pathalogists .....

   Attending Member .....

   Name and Address of Member's .....

   Ordinary medical attendant .....

5. **Details of Claim :**

Please fill up the items under which the benefits are claimed in respect of the above illness/accident giving ampont claimed and enclosing original receipt, bills, prescriptions and have the certificate completed by the doctor giving the medical attentions in respect of which a claim is made.

A. HOSPITALISATION

Benefit No.	*Description of treatment received*	*Cost of treatment*
1.	Room charges, Board and Nursing Attendance	Rs. .....
2 i)	Fees of Surgeon & Anaesthetist	Rs. .....
ii)	Operation Theatre charges, use of surgical appliances, Oxygen, Anesthesia, Blood Transfusion	Rs. .....
3.	Consultants and specialists fees including services of specialist for use of diagnnostic material fees including services of specialist for pathological tests, Physiotherapy, Phototherapy, heat treatment, deep-therapy, radiological and radium examination and treatment, all types of electrical treatment & physical masage.	Rs. .....
4.	Fees of Medical practitioners	Rs. .....
5.	Medicines, Drugs & Injections	Rs. .....

B. DOMICILIARY TREATMENT

1.	Fees of Medical Practioners	Rs. .....
2.	Consultant and specialists Fees including service of specialist for use of diagnostic materals as in Benefit No. 3 above	Rs. .....
3.	Nursing Charges	Rs. .....
4.	Medicines, Drugs & Injections	Rs. .....

I declare that I have/my dependent has sufferes the above described injuries/illness and that to the best of my knowledge and belief the foregoing particulars are in every respect true. I also declare there is no other insuranceor others source to cover the items claimed.

..... **Signature of Claimant** .....

Date :..... **Name of the Employees Concerned** .....

MEDICAL CERTIFICATE TO BE COMPLETED BY MEMBER'S DOCTO

I ..... **certify**

that ..... **was**

ill/injured .....

Full particulars of injury/illness.

Signature .....

Qualification of Doctor .....

Date : .....