PACIS
INSURANCE COMPANY LTD

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MEDICAL COVER PREFERRED PROVIDER OUTPATIENT CLAIM FORM

* Complete separate claim form for each member and on every visit
* All information must be supplied. Incomplete claim forms will delay claim processing
* Attach all medical invoices relating to the claim
* All members must be identi□ed by medical cards

Member Information

Scheme name _____

Patient name _____

Employee name _____

ID No. _____ Member Number _____

Date of Birth _____ Relationship: Employee/ Spouse/ Child

Telephone No. _____ Email Address _____

Medical Information (to be completed by the Doctor treating the patient)

Diagnosis _____

Is the condition recurrent or Chronic _____

Is the condition Congenital _____

Duration since Onset _____

Treatment _____

_____

_____

_____

Procedures/ Tests _____

Doctors Name _____

Doctors Signature _____ Date _____

Stamp _____

Authorization for release of information (Patient or parent/ Guardian must sign below)

I hereby warrant the truth of the above statements, that I have not withheld any information relating to this claim. I have no objection to Pacis insurance company Ltd and/or any of their representatives communicating with the doctor/ hospital I have consulted or visited regarding my medical information and have no objections to such release,

Signature of Patient or Parent (if patient is a minor) _____ Date _____