Aafiya

MEDICAL CLAIM FORM

Provider Name:	Patient Name:	
Insurance Company:	Patient Mobile No:	File No:
Company Name:	Member ID:	
Date Of Treatment: (dd/mm/yyyy)	Date Of Birth: (dd/mm/yyyy)	Gender:

Chief Complaints:			
Referral (if needed):			
Clinical Findings:		BP: TEMP: HR: RR:	
Diagnosis:	Diagnosis Code:	Date of Onset:	(dd/mm/yyyy)
PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED OTHERS ☐			
Treatment Plan:			

Requested Investigations:			Estimated Cost:
Prescription:	Dose:	Duration:	Estimated Cost:

MEDICAL PRACTITIONER DECLARATION: I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct. Dr.'s Name: Stamp: Signature: Date:	PATIENT'S DECLARATION: I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining insurance benefits. Patient 's signature {Parent if minor}: Date:

Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.