UAP OLDMUTUAL

OUT-PATIENT CLAIM FORM

Practitioners Name _____ **Practitioner's Official Stamp**

Postal Address _____

Tel No. _____ Mobile _____

Email _____

PATIENT'S PARTICULARS

Full Name of Patient_____Date of Birth _____

Full Name of Member (if patient is a dependant) _____

Member's Tel No. _____ Member No._____

Member's Employer Name _____ Dept. /Branch _____

Have you suffered from this sickness in the past? ☐ YES ☐ NO

If YES, when did it start and how frequent is it? _____

CONSULTATION/REFERRALS DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription	☐	Injection given	☐	Dispensed	☐	None ☐
RADIOLOGY:	X-Ray	☐	MRI/Cat Scan	☐	Other	☐	Other ☐
PATHOLOGY:	Haematology	☐	Microbiology	☐	Biochemistry	☐	Histology ☐

Hospital Name: _____Consultant Referred To: _____Specialty: _____

MEDICATION PRESCRIBED:

_____

_____

_____

Dr's Signature _____ **Date** _____

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature _____ **Date** _____

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