REIMBURSEMENT CLAIM FORM

ALL THE FIELDS ARE MANDATORY except for bank details where registered Mpesa number is provided.

Kindly ensure ALL the Mandatory Documents below are submitted to form part of this application form:

Duly filled outpatient/reimbursement claim form ☐ Copy of drug prescription form ☐ Original receipts ☐

Copy of lab request form ☐ Breakdown of the charges ☐ Registered Mpesa Mobile Number ☐

Bank details of the principal member ☐

**The Mpesa limit for reimbursement is Kes. 140,000. For any amount exceeding this limit, a bank transfer will be made.*

Practitioners Name:			
Postal Address:			
Tel No.:		Mobile:	
Email:			

Practitioner's Official Stamp

PATIENT'S PARTICULARS

Full Name of Patient:		Date of Birth:	
Full Name of Member (if patient is a dependent):		KRA PIN No.:	
Principal member ID No.		Principal member email address:	
Member's Mpesa Registered Mobile 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?			

MEMBER BANK ACCOUNT DETAILS FOR REIMBURSEMENT

Account Name:			
Account Number:			
Bank Name:		Branch Name:	
Swift Code/BAC (For international payments):			

CONSULTATION/REFERRALS

DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	☐ Prescription	☐ Injection given	☐ Dispensed	☐ None
RADIOLOGY:	☐ X-Ray	☐ MRI/Cat Scan	☐ Other	☐ Other
PATHOLOGY:	☐ Haemotology	☐ 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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