REIMBURSEMENT MEDICAL CLAIM FORM

1. Insured Member: …… EDP/FNPF no: ……...
2. Employer: ……... Sector: ……

   Email…… Contact phone no: ……..
3. Name of Patient: …… M/F …….. DOB …….
4. Name of Physician: ……...
5. Date Treated: …… Time Treated: ……
6. Diagnosis: ……
7. Cost Incurred: **ORIGINAL RECEIPTS ATTACHED**

   Doctor's Fee**:** $_____ Pharmacy Bills**:** $_____
   X-Ray & Lab**:** $_____ Specialist Fee**:** $_____
   Other Expenses: $_____

   TOTAL AMOUNT PAID $_____

Bank Account Code: _____

Bank Account Number: _____

Bank Name: _____

Branch: _____

Insured Members Signature: _____ **Date:** _____

It is mandatory requirement by Bank that where payment is rejected due to incorrect bank details provided will result in having $1.00 deducted from the claim payment as a fee for reloading.

IMPORTANT:

To ensure speedy handling of your claim please go thru this list and ensure everything that is required has been submitted with this Claim Form to FijiCare Insurance.

i)	Have you filled in Diagnosis in No. 6?	Yes	No
ii)	Are all Original Receipts Attached?	Yes	No
iii)	Specialist Referral: Have you attached copy of referral from your Doctor?	Yes	No
iv)	X-Rays & Lab Referral: Have you attached copy of referral letter from your Doctor?	Yes	No
v)	Optical & Dental Reimbursements: Have you obtained breakdown of Expenses?	Yes	No
vi)	Have you attached Medical Report?	Yes	No

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