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SAICOHEALTH MEDICAL CLAIM FORM

Section A: To be completed by the insured member

Patient Details

Member No.:		Employee No.:	
Patient Name:		Date of Birth:	
Email Address:		Mobile No.:	

Treatment Details

Country of Treatment:		Treatment Date:	
Date First Seen:			

Breakdown of Expenses (required)

Currency of Expenses:		Doctor's Fees *(Consultation):*	
Medicines:			
Others *(lab, x-rays, dental, vision..):*			
Total Amount Claimed:			

Beneficiary Details

Beneficiary Name *(Pay to)*:		IBAN (Mandatory):	
Bank Name:		Bank Address:	

Note: Reimbursement claims should be submitted to the Insurer within 90 days from the treatment date if the treatment is availed outside the country of residence, and within 60 days from the treatment date if treatment is availed within the residence country

Authorization: I the undersigned, hereby certify that all answers & all documents submitted with this Claim form are complete & true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me &/or any of my family members to provide SAICOHEALTH with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

Signature:		Date:	

Section B: To be completed by the provider *(Please write in CAPITAL LETTERS)*

Patient Name:		Age:	
Diagnosis:		ICD:	
Type of Treatment:		Date of illness *(first seen)*:	
Accident *(Date, Time & Cause)*:		Pregnancy *(Date of LMP)*:	
Hospitalization Date Admitted:		Date Discharged:	
Physian's Declaration:	I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.		
Physicians Signature:		Stamp:	

Section C: Attachments Required

- Invoices with proof of payment in the name of the patient
- Doctor's prescription for medicines, lab tests, x-rays, etc.
- Pharmacy invoice clearly showing name of medicine, quantity purchased, and price of each medicine.
- Copy of patient's SAICOHEALTH ID card.
- Medical reports, operative notes, discharge summary, progress reports etc.

Note: Detailed requirements are specified in the claims reimbursement checklist, kindly refer the same for accurate submission

Section D: Contact Information

Email: customerservice@saicohealth.com

Please refer to your SAICOHEALTH ID card for local phone no.