# REIMBURSEMENT CLAIM FORM

*Tel: 04-4043232, Fax: 04 2367979*

MEDICAL DETAILS (To be completed by Physician)

Clinical Findings:

Vital Signs: B/P:…… T: …… HR: …… RR: ……

Cause: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related ☐Others

Assessment / Diagnosis: ☐Acute ☐Chronic ☐Confirmed ☐Suspected

Type of treatment: Emergency treatment ☐ Elective treatment ☐

| INDICATE DIAGNOSIS NOT SYMPTOMS | Diagnosis Code |
|---|---|
| 1. | |
| 2. | |
| 3. | |

**Was In-patient required? If yes, attach Discharge Summary, Itemized invoices, Reports & receipts**_____

**Length of stay?** _____ **Referred from any other Provider?** _____**Cost**_____

(Doctors signature & stamp)