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NATIONAL CLAIM FORM - PRIMARY MEDICAL CARE

Sr. No. 540801

SECTION A: MEMBER DETAILS *(TO BE FILLED BY THE INSURED MEMBER)*

Member Name:	Insurance Company/(Payer) TPA Name:
Membership /Policy No:	Policy Holder:
Date of Birth:	CPR/Passport Number:
Gender: M ☐ F ☐	Member's Phone Number:
Medical Record No:	Provider Name:
Date of Treatment:	

SECTION B: MEDICAL SECTION *(TO BE FILLED ONLY BY THE TREATING PHYSICIAN)*

Main Complaint & Presenting Symptoms:	Clinical Findings:
Duration/History of illness:	Pre Existing Condition: ☐ Chronic Condition: ☐ Maternity ☐ EDD ..... Others (please specify):.....
Provisional / Final Diagnosis: (use ICD codes as appropriate)	

CONSULTATION

Plan of Management/Investigation	Medication

PRE-AUTHORIZATION SECTION (MEDICAL & INVESTIGATION REPORT MUST BE ATTACHED WHERE APPLICABLE)

ANTICIPATED LENGTH OF STAY:..... Days	ANTICIPATED COST:

Member Declaration

I the undersigned hereby certify that all statements & information provided concerning identification & the present illness or injury are TRUE. Furthermore, I authorize and request the Hospital to provide my Insurer / TPA with any information they request in connection with any treatment and/or services provided to me and grant them full access to my medical files.

Signature: .....

Date:.....

Medical Service Provider Declaration

I/We hereby certify that ALL information mentioned herein are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

Name of Doctor: .....

Signature: .....

Stamp: Date:.....

FOR INSURANCE COMPANY USE ONLY:

☐ Approved ☐ Not Approved Comments: .....

Approval No.: ..... Approved Validity : ....

Insurance Officer: Signature: Date: / / REF. No.

MedNet Claims center Fax: 17583009. Contains confidential medical information. Not to be handled by unauthorized personnel.