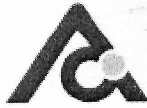

ASKARI GENERAL INSURANCE COMPANY LIMITED
AND WINDOW TAKAFUL OPERATIONS
HEALTH
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CLAIM FORM

(For Medical Reimbursement Claims)

Organization Name ______________________________
Employee Name ______________________________ Folio No. ________
Designation ______________________ Patient`s Name & CNIC ______________________
Patient`s Age ______ Relation with Employee ______________________ Gender: ☐ Male ☐ Female

Employee Contact No. ______________________________ (For Claim Processing Updates)

CLAIM DETAILS

Name of Clinic/Hospital and Doctor ______________________________
Date of Visit ________________ Consultation Fee (Rs.) __________ Cost of Medicine (Rs.) __________
Cost of Investigations/Lab. Tests/Radiology (Rs.) ______________ Total Cost (Rs.) ________________
Doctor sign/stamp and valid PMDC Number: ______________________ (To Be Filled by Treating Doctor)

NATURE OF CLAIM: (Check relevant)
☐ OPD ☐ HOSPITALIZATION ☐ MATERNITY ☐ DREAD DISEASE ☐ MMC ☐ SPECIALIZED INVESTIGATION

DOCUMENTS CHECKLIST: Please attach the following and tick ☒ to remember. Photocopies are not acceptable for payment.

- ☐ ORIGINAL PRESCRIPTION ON DOCTOR'S LETTERHEAD.
- ☐ FRESH PRESCRIPTION EVERY 3-6 MONTHS IN CASE OF DIABETES, HYRERTENSION, HEPATITIS & ASTHMA ETC. PHOTOCOPY ACCEPTABLE FOR IN-BETWEEN REFILLS.
- ☐ ORIGINAL CONSULTATION FEE RECEIPT.
- ☐ ORIGINAL MEDICAL STORE CASH MEMO WITH LICENCE NUMBER.
- ☐ VALID PMDC NUMBER OF TREATING DOCTOR IS MANDATORY FOR NON-PANEL CLAIMS.
- ☐ ORIGINAL DISCHARGE CARD.
- ☐ BIRTH CERTIFICATE ISSUED BY NADRA OR THE UNION COUNCIL.
- ☐ DR. ADVICE FOR MEDICINES, TESTS/ INVESTIGATIONS AND THEIR REPORTS.
- ☐ IN CASE OF MISSING DOCUMENTS OR WRONG TOTALLING, THE CLAIM WILL BE RETURNED BACK.
- ☐ CLAIMS OLDER THAN 90 DAYS ARE TIME BARRED AND MAY NEED SPECIAL APPROVAL.

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE. IF FOUND FRAUDULENT, INCOMPLETE OR INFLATED, I WILL BE RESPONSIBLE.

EMPLOYEE'S SIGNATURE ______________________ Date: ____/____/_______

BANK & ACCOUNT NO. (ONLY FOR EFT CLIENTS) ______________________________

FORWARDED BY (HR): ______________________ Date: ____/____/_______