amity آميتي®

Caring for you

AMITY HEALTH
MEDICAL PROVIDER CLAIM FORM

PROVIDER

Provider Name

PATIENT

Cover Number

Gender ☐ Male ☐ Female

Patient Name

Date of Birth DD / MM / YYYY

Patient File #

Mobile Number

CHRONIC

Known Conditions

HISTORY

Medication

Pathology

Radiology

ENCOUNTER

Service Date DD / MM / YYYY

Encounter Type: Outpatient ☐ Inpatient ☐

Emergency: Yes ☐ No ☐

Pre-Authorisation Number

Chief Complaint and Symptoms

DIAGNOSIS

Primary

Secondary

PATIENT DECLARATION

I declare that I am the patient, patient's parent or guardian (if patient is under 16 years of age) and that all information provided in the claim form is to the best of my knowledge true and correct. This declaration gives Amity the permission to get all information about my claim including, but not limited to, my current medical and previous medical providers/physician, pharmacy or any other person who has provided medical services to me or my dependants. I agree that a copy of this consent shall have the validity of the original.

Signature

Date DD / MM / YYYY

PROVIDER DECLARATION

I declare that all information mentioned is correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Name

Tel/Fax

Signature and Stamp

Date DD / MM / YYYY