amity آميتي®
Caring for you

AMITY HEALTH

MEMBER REIMBURSEMENT CLAIM FORM

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SECTION A: MEDICAL PROVIDER DETAILS

Provider Name | Provider License No

SECTION B: PATIENT DETAILS

Patient Name (as per card) | Patient Mobile No

Card Number | Patient File # | Patient DOB (D D / M M / Y Y Y Y)

SECTION C: CLAIM DETAILS

To be completed by attending Physician

Please tick: ☐ Outpatient ☐ Inpatient Emergency? ☐ Yes ☐ No

Pre-Authorisation No (if applicable)

Chief Complaint and Symptoms

What date did the patient first feel same/similar symptoms? (D D / M M / Y Y Y Y)

Significant Signs

Other Conditions

Date of this visit: (D D / M M / Y Y Y Y)

Diagnosis

MANDATORY: ICD Code (please tick) ☐ ICD9 ☐ ICD10 (See Amity Reference Guide)

Principal Code | 2nd Code | 3rd Code | 4th Code

Please tick where appropriate

☐ Congenital ☐ Chronic ☐ RTA ☐ Psychiatric ☐ Others (please specify) _____

☐ Check-up ☐ Acute ☐ Infertility ☐ Work-related ☐ Vaccination ☐ Pregnancy/Indicate LMP: _____

SECTION D: PROPOSED MEDICAL MANAGEMENT PLAN

Suggestive line(s) of management: Kindly list the recommended investigations and/or procedures

CODE	TYPE OF CODE USED	DESCRIPTION / SERVICE	QUANTITY	TYPE	COST

TOTAL COST

Anticipated Management Plan:

Referral Doctor's Name (if patient has been referred) | License No

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 Health 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 (D D / M M / Y Y Y Y)

MEDICAL PRACTITIONER 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

License No | Date (D D / M M / Y Y Y Y)