Atlas Insurance

Atlas Insurance Ltd.

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AtlasCare Health Insurance

IN-PATIENT MEDICAL CLAIM FORM

Do not leave any blanks, unanswered questions, medical reports, dates and/ or signatures, wherever applicable

SECTION A-CLAIM INFORMATION - TO BE COMPLETED BY THE CLAIMANT AND THE PATIENT

Medical / Surgical

1. Full name of Insured (Employer)
2. Full name of claimant
3. Full name of Employee — Telephone No.
4. Policy No. — Patient's Health Card/Credit letter No.
5. Patient's relationship to claimant: ☐ Employee ☐ Dependent Child ☐ Spouse Other-please describe
6. Full name of patient:
7. Date of birth — ☐ Male ☐ Female — CNIC or Passport No.
8. Usual Country of Residence — Nationality
9. Full address of patient's employer — Telephone No.
10. State the nature of the injury, illness or medical condition
11. On what date did: a) the symptoms first occur ?
    b) the patient last word day ?
12. Does treatment relate to an accident ? ☐ Yes ☐ No.

If yes : a) what was the date of the accident ?

b) give brief details of where and how the accident happened ?

13. Name and address of usual doctor . — Telephone No.
14. Has the patient consulted any doctor for the present or any related medical condition ? ☐ Yes ☐ No.

If yes, for each doctor and hospital consulted state name, full address and dates first consulted.

Date	Name & Address	Treatment / Consultation

15. If we require an independent medical examination:

a) Where is the patient now located ?

b) Who should be contacted to make the necessary arrangements ?

16. Give details of any other health, medical or travel insurance, Workman's Compensation, Social Security or other medical benefits to which the Patient may be entitled

17. Is this a continuation of a previous or current treatment, or treatment for which you have already claimed under this Policy or any other policy ?

☐ Yes ☐ No. If yes, please give brief details :

18.

Date of treatment	List of expenses for which reimbursement is now claimed	Currency and amount claimed / paid

I, the above claimant, hereby authorize any doctor, hospital clinic or any other person who has any record or information about me, to provide Atlas Insurance to finalize this claim, and declare that all the above particulars are true and complete to the best of my knowledge and belief. Any photocopy of this authorization shall be taken as the original copy.

Signature of Patient / Claimant
Date

Signature of Employer
Date

If the patient is minor (Under 18). the claimant should sign

SECTION B - TO BE COMPLETED BY THE TREATING PHYSICIAN

1. **How long have you been the patient's doctor ?**
2. **How far back in time do your records go ?**
3. **Please give the name and address of the referring physician**
4. **On what date were you first consulted for the injury, illness or medical condition concerned, on for any related condition ?**
5. **Please give your diagnosis of the injury / illness / condition:**
6. **If an accident is involved, how did it happen ?**
7. **Please give details of the treatment given or prescribed:**
8. **Please give a brief history of this or any related condition, with date(s) on which any previous consultations or treatment took place :**
9. **Have you any reason to believe that the same or any related medical condition has been diagnosed or treated previously by any other doctor or hospital ?**

Dates	Treatment / Consultation

Maternity:- Please mention of Normal / C-Section, D&C, Abortion

10. **In respect of claims for maternity care, please state expected delivery date:**

    and the date you were first consulted for this condition :
11. **Please PRINT your name:**

Address

Telephone No.

Signature of treating physician
Date

Physician's Rubber Stamp

HOW TO GO ABOUT MAKING A CLAIM

1. Responsibility lies with the employee to inform us and his employer about his intended hospitalization / surgery.

Emergency Cases :

In an event of emergency the patient could rush to any hospital whether it is or is not a part of our Panel Hospital Network (PHN). The patient / insured employee is required to intimate Atlas Insurance within 24 hours of hospitalization through phone or fax. The charges incurred by the insured will be reimbursed Provided that the total expense falls within the limit allocated to him / her.

If the hospital falls under the PHN list then the insured could utilize his / her credit facility only by producing a copy of the OCL, copy of which the hospital will retain, or a Atlas identification card. The employee will be served as a private patient until he / she gives a OCL or a Atlas Identification. Being a part of the PHN the hospital expenses will be settled directly by Atlas insurance and no cash outlay would be required by the insured.

Non Emergency Cases :

When going for a planned surgery or hospitalization the insured has to inform Atlas insurance beforehand. Atlas insurance will issue relevant claim forms which should be submitted to the company prior to undertaking in patient hospital treatment and supporting medical information not later than 30 days thereafter. On receipt of the completed forms, Atlas insurance may counsel with any hospital about the Patient illness and treatment together with all other relevant details. Thereupon the employee will be issued a credit letter / treatment plan. When the insured goes to the hospital he must submit the original credit letter / treatment plan without which he / she will not be entertained. Being a part of the PHN the hospital expenses will be settled directly by Atlas insurance and no cash outlay would be required by the insured.

2. In emergency / non emergency cases, if the treatment is availed in the non-PHN, than the claim will be submitted to Atlas Insurance on prescribed forms with the following guidelines.

2 i. Use a new Claim Form for each separate claim or course of treatment.

2 ii. The insured Person or his / her legal representatives must complete all questions in section A of the Claim Form and signs it.

2 iii. The treating Physician must complete all questions in Section of the Claim Forms, rubber stamps and sign it.

2 iv. Send the Claim Form, fully completed by the Insured Person and the treating Physician, together with all relevant documents to the Company.

3 Outpatient Services are not subject to payment guarantees, and covered claims will be settled on a reimbursement basis.

✓ Incomplete Claim Forms cannot be accepted for processing of payments.
✓ Attach originals of all relevant documents and bills.
✓ Photocopies are not acceptable for processing a claim.