

CLAIM FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and fully completed form. All documents will be handled in strict confidence by our medical team. Failure to provide the required information may result in your claim not being settled. Thankyou

1 PATIENT INFORMATION

Surname <i>Khamim</i>	Card No.
First Name <i>Fauz</i>	Mobile Doctor ID.
Address	
Tel. No.	Fax No.
D.O.B./Age	Email

2 TREATING FACILITY INFORMATION

TREATING MEDICAL OFFICER / REFERRING DOCTOR		HOSPITAL / MEDICAL FACILITY	
Name	: <i>Dr. Pratik Premjani</i>	Name	:
Tel. No.	: <i>04-2529935</i>	Tel. No.	:
Fax. No.	:	Fax. No.	:
Email	: <i>dentistree.dentalclinic@gmail.com</i>	Email	:
Address	:	Address	:

3 MEDICAL INFORMATION (to be completed by the Physician)

Presenting symptoms	
Date when symptoms first occurred	
Has this or any similar condition existed previously?	<input type="radio"/> Yes <input type="radio"/> No If yes, please provide details/dates*:
Diagnostics / Investigations	<i>consultation - deep bite, Class II</i>
Treatments / Medications	<i>Consultation, OPG, leg & study model</i>
Provisional diagnosis	

*Please continue on a blank sheet if more space required

4 PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries/illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature: *Dr. Pratik Premjani*
 Specialist Orthodontics
 DHA-00058483-003
 Date: *20/10/2014*
 DENTISTREE DENTAL CLINIC

5 PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish MSH International information with regard to any medical history, condition or services. I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature: _____
 Date: _____