Sagarmatha Insurance Co. Ltd.

"SURAKSHAN" Bhawan, Naxal ,Kathmandu, Nepal.
Tel: 977-1-4412367 Fax No.:977-1-4412378
E-MAIL: sagarmatha@insurance.wlink.com.np

MEDICAL CLAIM FORM

POLICY NO:
CLAIM NO:

POLICY HOLDER:

NAME AND ADDRESS OF THE POLICY HOLDER :

PATIENT/INJURED PERSON

NAME AND ADDRESS OF THE PATIENT/INJERED :

EMPLOYMENT/OCCUPATION :

AGE :

TELEPHONE NO. :

INJURY/ILLNESS

DATE OF COMMENCEMENT OF ILLNESS/ DATE AND PLACE OF ACCIDENT :

NATURE OF ILLNESS
HOW DID ACCIDENT OCCUR :

NATURE OF INJURIES/ SYMPTOMS OF ILLNESS :

HAVE YOU/SHE/HE SUFFERED PREVIOUSLY FROM SIMILAR ILLNESS? IF "YES" PLEASE GIVE DETAILS :

ARE YOU STILL UNDERGOING TREATMENT ON THIS ILLNESS/INJURY? IF SO, PLEASE GIVE DETAILS :

MEDICAL PRACTITIONER

NAME AND ADDREDD OF SPECIALIST/ SURGEON IN ATTENDANCE :

ARE YOU OR THE CLAIMANT ENTITLED TO ANY COMPENSATION OR CLAIM ON ANY OTHER MEDICAL INSURANCE IN RELATION TO THIS EVENT? : YES • NO •

IF YES, PLEASE GIVE DETAILS :

DECLARATION

I/WE HEREBY DECLARE THAT THE ABOVE STATED FACTS AND STATEMENTS ARE TRUE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF AND THAT I/WE HAVE NOT WITHHELD FROM SAGARMATHA INSURANCE COMPANY LIMITED. ANY MATERIAL INDORMATION CONNECTED WITH THIS CLAIM.

_____
INSURED PERSON'S SIGNATURE

DATE:

_____
INSURED SIGNATURE

NAME OF PATIENT	:
NAME OF GENERAL PRACTITIONER BY WHOM THE FERERENCE WAS MADE	:
PLEASE STATE WHY THE INVESTIGATION	:
TREATEMENT WAS NECESSITATED	:
WHEN WERE YOU FIRST CONSULTED IN THIS CONNECTION?	:
IN YOUR OPINION WHEN DO YOU THINK THA AILMENT COULD HAVE BEGUN OR BEEN CONTRACTED	:
YOUR DIAGNOSIS OF DISEASE	:
STATE BRIEFLY THE HISTORY ON INJURY/AILMENT	:
DETAILS OF TREATMENT OR OPERATION	:
YOUR PROGNOSIS	:
PERIOD OF DISABLEMENT	:

I CERTIFY THAT I AM THE GENERAL PRACTITIONER/SURGEON OF THE PATIENT REFERRED TO ABOVE, AND I APPROVE THE SERVICES FOR WHICH THIS CLAIM IS MADE.

_____
SIGNATURE OF THE G.P/SURGEON/CONSULTANT

NAME OF G.P./SURGEON/CONSULTANT

ADDRESS:

QUALIFICATIONS:

DATE: