



SHAHEEN INSURANCE COMPANY LIMITED

Joint Venture Of Shaheen Foundation-PAF, Hollard Insurance and FCSC

H.No.46, Khayaban-e-Suharwardy, Islamabad P.O Box No: 44000

UAN: (92-51)111-765-111 Fax.No: 92-51-2829515



OUT PATIENT EXPENSE CLAIM FORM

Date: _____

Name of Patient: _____

Shaheen ID No: _____

Name of Employee (If Patient is dependent): _____

Shaheen ID No: _____

Relation with Employee (If Patient is dependent): _____

Sex (Tick One): 1. Male 2. Female

Designation of Employee: _____

Date of Birth: _____

Name of Company/Organization (For Group Insured): _____

Address of Employee (For Individual/Family Insured): _____

Claim Type (Tick whichever is applicable): 1. Out-Patient Department 2. Dental 3. Eye

S.No	Receipt No	Date	Type of Charges (Tick as required)			Treating Doctor	Amount (In Rs)
1.			C-Fee	Medicine	Investigation		
2.			C-Fee	Medicine	Investigation		
3.			C-Fee	Medicine	Investigation		
4.			C-Fee	Medicine	Investigation		
5.			C-Fee	Medicine	Investigation		
6.			C-Fee	Medicine	Investigation		
7.			C-Fee	Medicine	Investigation		
8.			C-Fee	Medicine	Investigation		
9.			C-Fee	Medicine	Investigation		
10.			C-Fee	Medicine	Investigation		
11.			C-Fee	Medicine	Investigation		
12.			C-Fee	Medicine	Investigation		
13.			C-Fee	Medicine	Investigation		
14.			C-Fee	Medicine	Investigation		
15.			C-Fee	Medicine	Investigation		
16.			C-Fee	Medicine	Investigation		
17.			C-Fee	Medicine	Investigation		
18.			C-Fee	Medicine	Investigation		
19.			C-Fee	Medicine	Investigation		
20.			C-Fee	Medicine	Investigation		
21.			C-Fee	Medicine	Investigation		
22.			C-Fee	Medicine	Investigation		
23.			C-Fee	Medicine	Investigation		
24.			C-Fee	Medicine	Investigation		
25.			C-Fee	Medicine	Investigation		
26.			C-Fee	Medicine	Investigation		
27.			C-Fee	Medicine	Investigation		
28.			C-Fee	Medicine	Investigation		
29.			C-Fee	Medicine	Investigation		
30.			C-Fee	Medicine	Investigation		
Grand Total						Rs.	
Amount in words:							

I hereby declare that the amount stated is correct and was incurred by me for medical expenses. Furthermore, I agree that in case of discrepancy in documents is found then the company has right to refuse the said claim

Signature of Employee/Individual
(As on National ID Card)

Verification of Employer with Seal
(For Group Insured Only)

NOTE:- Instructions Overleaf

INSTRUCTIONS FOR FILLING THE FORM (To be observed strictly)

DOCUMENTS REQUIRED:-

1. **OPD Claim Form** Original (Completely Filled)
2. **Consultancy Payment Receipts** Original (For Homeopathic Cases Only -- In case of consultation payment being mentioned on the doctor's homeopathic prescription, then the prescription should be signed by prescribing homeopathic doctor with stamp, his name, contact number clearly mentioned with the signature and the fee charged mentioned on the slip in his own hand writing)
3. **Doctor's Prescription** Original (Chief Complaints, Diagnosis, Investigations (If any) , Treatment must be mentioned in the prescription. In case of long term medication, the doctor's prescription advising use for a specific period or advising use of medicine till next consultation should be attached with the claim and photocopy of this prescription should be attached with every medicine purchase claim related to this prescription)
4. **Medicine Receipts** Original (Also submit Doctor's Prescription supporting purchase of medicines. No consultation fee charges are allowed on medicine receipts)
5. **Investigation Reports** if any Original (Also submit Doctor Prescription having advice for investigations)
6. **Investigation Payment Receipts** if any Original
7. **Shaheen Health Card & National Identity Card** Copy (They should be valid at time of presentation)

NOTE:-

- Kindly photocopy all claims being sent to our office and maintain them in your record for future reference.
- No Overwriting or Additional Changes to already prescribed prescriptions/receipts is allowed.
- No Prescriptions/Receipts are allowed to be claimed on blank papers having no title of the chemist/doctor/hospital.
- For pediatric vaccination cases, attach photocopy of ` Immunization Schedule/Chart` attested by gazette officer.
- For continuous medication, attach photocopies of doctor prescription showing brief history, diagnosis, medicine advised mentioning long term use with every medicine claim related to this prescription (this doctor prescription is valid for 3 months after which follow-up (new prescription) is required according to WHO `health for all` program).
- All medicine cost/bills incurred will be checked with rate lists provided to us via hospital/clinics and chemists (Rate lists updated every 15 days)
- Claims presented after 15 days of expiry of policy period will not be re-imbursed.
- OPD claim expenses incurred should be claimed within 3 months
- In case of lack of documents submitted for claim re-imburement, they should be submitted within 1 month after receiving letter for their submission or the claim will stand refused/rejected after expiry of period of 1 month.

Dr. Shaan Khan
CMO
SICL-ISB