



## REIMBURSEMENT MEDICAL CLAIM FORM

1. Insured Member: ..... EDP/FNPF no: .....
2. Employer: ..... Sector: .....  
Email..... Contact phone no: .....
3. Name of Patient: ..... M/F ..... DOB .....
4. Name of Physician: .....
5. Date Treated: ..... Time Treated: .....
6. Diagnosis: .....
7. Cost Incurred: **ORIGINAL RECEIPTS ATTACHED**  
Doctor's Fee: \$ ..... Pharmacy Bills: \$ .....  
X-Ray & Lab: \$ ..... Specialist Fee: \$ .....  
Other Expenses: \$ .....

**TOTAL AMOUNT PAID \$** \_\_\_\_\_

**Bank Account Code:** \_\_\_\_\_

**Bank Account Number:** \_\_\_\_\_

**Bank Name:** \_\_\_\_\_

**Branch:** \_\_\_\_\_

**Insured Members Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

It is mandatory requirement by Bank that where payment is rejected due to incorrect bank details provided will result in having \$1.00 deducted from the claim payment as a fee for reloading.

**IMPORTANT:**

To ensure speedy handling of your claim please go thru this list and ensure everything that is required has been submitted with this Claim Form to FijiCare Insurance.

- |  |     |    |
|--|-----|----|
| i) Have you filled in Diagnosis in No. 6?  | Yes | No |
| ii) Are all Original Receipts Attached?  | Yes | No |
| iii) Specialist Referral: Have you attached copy of referral from your Doctor?         | Yes | No |
| iv) X-Rays & Lab Referral: Have you attached copy of referral letter from your Doctor? | Yes | No |
| v) Optical & Dental Reimbursements: Have you obtained breakdown of Expenses?           | Yes | No |
| vi) Have you attached Medical Report?  | Yes | No |

*"better health for Fiji"*