Avenue Healthcare

Medical Expenses Reimbursement Form

I To be completed by the Claimant

Note: Your claim **will not** be considered unless you attach original detailed receipts and copies of prescriptions for each chemist's cash sale. Only NHIF registered hospitals and other Avenue Approved providers will be accepted.

1. Name of Claimant _____ (Patient's Full Names)

Avenue Member # _____ /_____ / _____ Dependant of _____ (if applicable)

2. Address: PO Box _____ Town: _____ Postal Code _____

II To be completed by the Attending Doctor / Medical Personnel

1. Nature of Illness / Diagnosis _____

_____

2. When did the illness start? _____ 3. Has the patient suffered from this illness before ? YES / NO

If yes, when did the illness first start and how frequent is it ? _____

_____

4. In your opinion is this illness chronic? YES / NO _____

5. Give details of treatment, management and prescription given

_____

_____

_____

I certify that the above treatment was administered by me / given on my instructions by other practitioners and medical personnel.

_____ _____

Doctor's Name & Signature Doctor's / Medical Centre's Stamp

_____ _____ _____

Doctor's / Medical Centre's Address Telephone number Date

III Declaration (To be signed by the patient or legal guardian)

I, on my behalf / or on that of my dependant certify that the above information is true. I have not withheld or misstated material information related to this claim and have no objection to Avenue Healthcare personnel or their representatives obtaining further information or clarification from my Medical Doctor (s) or Health Centre.

_____ _____

Patient's or Guardian's Signature Date

IV Details of the Expenses

ITEM	DESCRIPTION / DETAILS OF MEDICAL SERVICES RENDERED	AMOUNT in Kshs	
1			
2			
3			
4			
5			