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SASAdoctor

OUTPATIENT CLAIM FORM

INVOICE NUMBER

This form must be completed for every patient receiving treatment. Please complete a separate form for each visit and attach your invoice and other documentation for processing.

Please complete the form in block letters.

PATIENT INFORMATION

First Name Surname

Member Number Gender M F Date of Birth: D D M M Y Y Y Y

MAIN MEMBER DETAILS

First Name Surname

Employer

SERVICE PROVIDER DETAILS

Name of provider

Consulting date D D M M Y Y Y Y Consulting doctor

DIAGNOSIS	CODE	DIAGNOSIS	CODE
Other (Specify diagnosis)			

CONSULTATION SERVICE PROVIDED	CODE	DESCRIPTION	COST
Laboratory Tests			
Other diagnostics			
Other diagnostics			
Procedures/ Tests			
Prescribed drugs/ Attach copy of prescrption	CODE	QUANTITY / DOSAGE DESCRIPTION	
		Total Medication Costs (KShs)	

PROVIDER'S DECLARATION

I certify that the above patient has received the services & treatment noted on this form, diagnosed and administered by myself and that this claim is in accordance with my specified treatment.

PROVIDER STAMP

Signed _____ Date: D D M M Y Y Y Y

PATIENT GUARDIAN DECLARATION

I _____ certify that the above patient has received the services & treatment noted on this form, diagnosed and administered by myself and that this claim is in accordance with my specified treatment.

Email Address _____ Date: D D M M Y Y Y Y

Signed _____ Phone Number _____