**BU EMPLOYEES HEALTHCARE SCHEME**

**JGI IPD CLAIM REIMBURSEMENT FORM – POLICY YEAR 2019**

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| **CLAIM TYPE** | INPATIENT | PRE/POST |

**SECTION I (To be Completed by Employee)**

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| Company Name: | Bahria University | | | | | Policy No: \_\_\_\_\_\_\_05932\_\_\_\_\_\_\_\_\_\_\_ | | |
| Employee Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Relation: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Company ID No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | JGI ID#\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Campus/ CU/ BUHO Directorate: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| I, the above named employee, declare that the information given in this form is correct to the best of my knowledge. I hereby authorize any Hospital or Doctor / Surgeon who has attended to me or to my family member to furnish to the JGI (the healthcare service provider company) any information they may require concerning our medical history, examination or treatment etc. This is my IPD / Maternity Claim No.\_\_\_\_\_\_\_\_\_\_ (mention claim no 1st, 2nd, 3rd, etc applied during the policy year) | | | | | | | | |
| Amount of claim Rs.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**SECTION II (To be Completed by Attending Physician / Surgeon)**

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| Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Name & Address of referring Doctor if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Name or Physician /Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Mobile No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| PMDC No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of Hospital & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Source of Admission: | | Emergency: | | | | Elective/ Planned | | | other |
| Patient Registered as: | | | | Bed Patient: | | | Outpatient | | |
| Date of Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Date of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Presenting Complaints & Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Associated Disease & Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Previous Medical / Surgical History with Diagnosis & Durations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Date of Operation (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Final Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Treatment Given during hospitalization including detail of all investigations and medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Doctor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Hospital Seal and Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

**SECTION IlI (Verification by Policy Holder / Employer)**

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| I hereby declare that the information given in the claim form is complete/ correct and signed by the concerned doctor. The amount mentioned was incurred by the employee for medical expenses. |
| Signature with Seal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OIC Healthcare (BU Campus)/CU & Director /DD/ AD (BUHO) |
| DD Admin BUHO Signature with Seal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Documents required for IPD reimbursement** | **Tick** | **Documents required for IPD reimbursement** | **Tick** |
| i. Doctor prescriptions of tests / medicines on letter head |  | iv. NADRA birth certificate (Maternity case) |  |
| ii. Medical reports related to the disease i.e. X-ray, ultrasound (**must in Maternity case**), etc. with supporting prescriptions before and after 30 days of admission |  | v. Original receipts of Diagnostic centers, laboratories & Medicine receipt/ charges (original) of pharmacy/ medical store, etc (showing name of drug & quantity) before and after 30 days of admission |  |
| iii. Itemized hospital bill with breakup of expenses (photocopy not acceptable) / Detail breakup of amount required |  | vi. Discharge summary on Hospital pad duly signed by concerned Doctor |  |
| **Please note that no medical claim (OPD/IPD) will be entertain pending more than 2 months** | | | |

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