Adamjee Insurance Company Limited
Window Takaful Operations
Health Takaful
Health Takaful - In-Patient Claim Form

INSTRUCTIONS: (Please read them carefully)

1. In order for us to provide you with efficient services, please complete the form accurately in "CAPITAL LETTERS" (photocopies can also be used).
2. Filled forms should be sent to Adamjee Insurance Company Limited – Window Takaful Operations within 30 days of the expense incurred date.
3. Please attach the following documents with the form for fast processing of your claim.

I- Original hospital bill with type of accommodation (room type) and break-up of total bill according to:
(a) Room charges (b) Lab tests and Radiology charges (c) Consultation charges (d) Anesthesia charges (if any) (e) Surgeon fee with details (if any) (f) Operation Theatre charges (if any) (g) Medicines (used during hospitalization) (h) Other miscellaneous medical expenses like oxygen, blood, etc.

II- Laboratory or Radiology reports along with doctor's advice

III- Proper itemized bill(s) and payment receipt(s) of the hospitalization

IV- Proper itemized bill of the medicines purchased, supported by the physician's prescription

V- Hospital discharge/clinical summary (in case of hospitalization)

VI- Copy of birth certificate(s) in case of child birth

To be completed by the Employee:

Employee's Mandatory Information (In CAPITAL LETTERS)	
Bank Account Tittle Name	

Hospitalization Claim ☐ Pre & Post Hospitalization Claim ☐

Name of the Company: _____ PMD No.: _____

Name of Employee: _____ Credit Letter No.: _____

Name of the Patient: _____ Date of Birth: _____

Relationship with Employee: _____ Claimed Amount: _____

CNIC No. of Employee: _____

DETAILS OF ILLNESS:

Date of illness first noticed: _____ Nature of illness: _____

Has the claimant suffered from this illness before? YES ☐ NO ☐

If yes, then please provide date(s) and details: _____

DETAILS OF HOSPITALIZATION:

Name of Hospital attended: _____

Name of Treating Physician: _____

Date of Admission: _____ Date of Discharge: _____

Emergency treatment or elective: _____

Is the patient entitled to any other benefit or compensation from any other source? If so, name the companies or other sources and give the amount of benefit payable by each.

DECLARATION:

I hereby certify that all answers, and all documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any company, institution or any other person who has any record or information about me and/or of my family members to provide Adamjee Insurance Company Limited – Window Takaful Operations with the information, including copies of their record with reference to any sickness or accidents, any treatment, examination, advice or hospitalization, any photocopy of this declaration shall be taken as the original copy.

Signature of the Patient _____ Signature & Seal of the Employer _____ Date: _____

To be completed by Attending Physician/Hospital: _____

Patient's Name: _____

Final Diagnosis: _____ Procedure: _____

Are you the patient's primary physician? YES ☐ NO ☐

When did the patient first consult you for this complaint? Day: _____ Month: _____ Year: _____

I hereby certify that my answers to the following questions are correct and true to the best of my knowledge and belief:

Signature & Stamp of the Attending Physician: _____

Name & Address: _____

Phone No.: _____ Fax No. : _____

Mobile No.: _____ Date: _____

NOTE:

For speedy settlement of the claim, we request you to please fill in each and every column with as much detail as possible. Please do not leave any column blank.

FOR OFFICIAL USE ONLY

i. Is the person covered under the policy? Yes/No _____

ii. What is the insured maximum limit:

Per Ailment Rs. _____

R/B-Limit Rs. _____

PC-Limit (if concerned) Rs. _____

iii. Are the bills/prescriptions attached in the order? Yes/No _____

iv. Is the amount claimed within the limit? Yes/No _____

v. Amount claimed: _____

vi. Amount approved: _____

vii. Signature of approval: _____