Heritage
Insurance Company
A member of LIBERTY

THE HERITAGE INSURANCE COMPANY KENYA LIMITED
Liberty House, Processional Way
PO Box 30390-00100, Nairobi, Kenya
Contact Centre 0711 076 333
Emergency 24 Hours Service Line
0733 750004/0733 550050
0728 6077689/0728 111001/0728 111002
e healthcareundertakings@heritage.co.ke
w www.heritageinsurance.co.ke

Health Cover 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 for processing. The patient should be given a duplicate copy for their records. Please attach a detailed invoice where possible to expedite payment.

Please complete the form in block letters.

IMPORTANT: The Heritage Insurance Company Kenya Ltd will decline illegible or incomplete claims.

PATIENT DETAILS

First name | Surname

Member No. | Dep Code | Gender (M / F) | Date of Birth (D D M M C C Y Y)

MAIN MEMBER DETAILS

First name | Surname

Employer

SERVICE PROVIDER DETAILS

Name of provider | Consulting physician

Heritage provider no. | Treatment date (D D M M C C Y Y)

Should hospitalisation be required, please complete a Pre-authorisation Approval Request form.

DIAGNOSIS CODING	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)
	Allergic Rhinitis	J30	C-Section	O82	Malaria	B54	Pharyngitis	J02
	Anaemia	D64	Dental Caries	K02	Myopia	H52	Pneumonia	J18
	Antenatal screening	Z36	Dermatitis	L30	Optical examination of eyes and vision	Z01	Spontaneous birth	O80
	Bronchitis	J40	Diarrhoea/Gastro	A09			Tonsillitis	J03
	Candidiasis	B37	Gastritis	K29	Otitis media	H66	URTI	J06
	Conjunctivitis	H10	Influenza	J10	Peptic Ulcer	K27	UTI	N39
Other (Specify diagnosis)								

CONSULTATION	0190 GP	0191 Specialist	11001 Optical	8101 Dental	Other	COST
Is this a maternity related claim?				Yes	No	

SERVICE PROVIDED	CODE	DESCRIPTION	COST
Laboratory Tests			
Other diagnostic procedures/tests			
Optical			
Dental			
Prescribed drugs (attach copy of prescription)	CODE	QTY / DOSAGE / DESCRIPTION	
		Total medical costs (indicate currency)	

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 C C Y Y)

PATIENT/PATIENT'S GAURDIAN DECLARATION

I _____ hereby declare the above stated to be true and in accordance with the health insurance rules. I confirm that the details given above are correct, that the amount claimed herein is not claimable from another source, and that the patient is a member or dependant on Liberty Blue/Heritage Blue health insurance. I authorise the provider of services to disclose the nature of illness to the Insurer for its confidential use and I agree that no awards will be made for this treatment unless contributions are received in respect of the period of treatment. The Heritage Insurance Company Ltd reserves the right to recover any amounts paid to providers in excess of benefits directly.

Signed (Patient/Guardian) | Date (D D M M C C Y Y)

Cell phone no. | Email address