THT
Total Health Trust Ltd.

A member of LIBERTY

BLUE CLAIM FORM

2, Marconi Road, Palmgrove Estate, Lagos
(SMS AND WHATSAPP- +234 (0) 7013674541)
Email: claimsmailroom@totalhealthtrust.com

24 Hours Call Center Numbers

01-4482105 | 01-4607560
+234 (0) 708 0687 600
5EF0E0DD

ALL FIELDS/ SPACES MUST BE FILLED FOR YOUR CLAIMS TO BE PROCESSED
A CLAIM FORM MUST BE USED PER PATIENT PER ENCOUNTER

INVOICE NO: _____

PATIENT DETAILS

FIRST NAME* _____

SURNAME* _____

MEMBERSHIP NO* _____ DEP NO* _____

DOB* _____ GENDER* (M/F) _____

ADMISSION DATE* _____

SERVICE PROVIDER DETAILS

NAME OF PROVIDER* _____

CONSULTING PHYSICIAN* _____

HEALTH PROVIDER NO* _____

TREATEMENT DATE (OUTPATIENT)* _____

DISCHARGE DATE* _____ LOS* _____

DIAGNOSIS _____

CONSULTATION

0190 GP	0191 SPECIALIST	11001 OPTICAL	8101 DENTAL	OTHERS	COST

S/N	TARIFF CODE	DESCRIPTION OF SERVICE PROVIDED. (For drugs, kindly detail dosage and duration)	QUANTITY	COST

PROVIDER'S DECLARATION

I CERTIFY THAT THE ABOVE PATIENT HAS RECEIVED THE SERVICES & TREATMENT NOTED ON THIS FORM; DIAGNOSED AND ADMINISTERED BY ME AND THAT THIS CLAIM IS IN ACCORDANCE WITH MY SPECIFIED TREATMENT.

SIGNED _____ DATE D D M M C C Y Y

PROVIDER'S STAMP

PATIENT'S DECLARATION

I HEREBY DECLARE THE ABOVE STATED TO BE TRUE AND THAT THE DETAILS GIVEN ABOVE ARE CORRECT. I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS TO BLUE FOR ITS CONFIDENTIAL USE. TOTAL HEALTH TRUST RESERVES THE RIGHT TO RECOVER ANY AMOUNTS PAID TO PROVIDERS IN EXCESS OF BENEFITS DIRECTLY

SIGNED _____ DATE D D M M C C Y Y

_____

PATIENT'S PHONE NUMBER