

Out-patient claim form

Complete a separate claim form for each member and for every visit.
 Ensure the ailment does not fall under excluded conditions.
 Services rendered must be in accordance with the benefits of the member's plan.



Name of healthcare provider: _____

Employer's name: _____

Principal member's full name: _____

Patient's full name: _____ Age: _____ Sex: _____

Patient's relationship to principal member: _____

Membership number: _____

Plan Prime-plan Flexi-plan Premier-plan Other _____

Date: _____ Time: _____ Signature of member: _____

Diagnosis:				Tshs.
Treating Doctor:		Consultation:		
Laboratory investigations:	Tshs.	Other investigations:	Tshs.	
Injections and dressings:	Tshs.	Pharmacy	Tshs.	
Sub-total:		Sub-total:		

Doctor's Signature _____ Date _____
 and stamp

"I agree with the cost shown on the bill"

Patient's Signature _____ Date _____

Strategis Insurance (Tanzania) Limited
 P.O. Box 7993
 Dar es Salaam
 Tanzania
 Tel: 255 – 22 2602570, 2602574, 2602579
 Helpline: 255-22-2602581
 Fax: 255-22-2602385
 Email: doctors@strategistz.com