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.

Strategis Insurance

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 _____

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