



The United Insurance Company Of Pakistan Ltd.

A Member Company of United International Group

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HEALTH GUARD CLAIM FORM

ORGANIZATION NAME AUTHORITY LETTER NO
 EMPLOYEE NAME
 DESIGNATION PATIENT NAME
 PATIENT AGE RELATION WITH EMPLOYEE SEX.MALE/FEMALE

OUT DOOR TREATMENT (OPD)

(Please attach itemized bill, original prescriptions, lab. reports and receipts)

NAME OF CLINIC / HOSPITAL AND DOCTOR
 CONSULTANT FEE COST OF MEDICINE
 COST OF INVESTIGATIONS/LAB TESTS TOTAL COST

SPECIALIZED INVESTIGATION

NAME OF HOSPITAL / INSTITUTION
 REFERRING SPECIALIST / CONSULTANT
 COST OF INVESTIGATION / PROCEDURE

PLEASE TICK WHICH EVER IS APPLICABLE

CAT SCAN (Computerized Axial Tomography)
 MRI (Magnetic Resonance Imaging)
 NUCLEAR SCAN
 ANGIOGRAPHY
 ERCP (Endoscopic Retrograde Cholangio - pancreatography)

DATE OF INTIMATION DATE OF APPROVAL

HOSPITALIZATION TREATMENT

NAME OF HOSPITAL _____

NAME OF TREATING PHYSICIAN / SURGEON _____

DATE OF ADMISSION _____ DATE OF DISCHARGE _____

PLEASE TICK WHICH EVER IS APPLICABLE

DIAGNOSIS / PROCEDURE

- | | | |
|--------------|--------------------------|--|
| 1. MEDICAL | <input type="checkbox"/> | _____ |
| 2. SURGICAL | <input type="checkbox"/> | _____ |
| 3. MATERNITY | <input type="checkbox"/> | <i>Please mention if normal, C-Section, D&C, abortion etc.</i> |
| • ANTENATAL | <input type="checkbox"/> | _____ |
| • NATAL | <input type="checkbox"/> | _____ |
| • POSTNATAL | <input type="checkbox"/> | _____ |

TOTAL COST OF HOSPITALIZATION _____

ROOM CHARGES _____

O.T./LABOR ROOM CHARGES _____

COST OF SURGEON _____

COST OF ANESTHETIST _____

INVESTIGATION AND LAB. CHARGES _____

CONSULTANT/M.O. VISIT CHARGES _____

OTHERS (Name & Cost) _____

EMPLOYEE SIGNATURE

NAME, SIGNATURE AND SEAL OF DOCTOR/HOS-ADM

EMPLOYER SIGNATURE

FOR OFFICE USE ONLY

SANCTIONED AMOUNT _____

OUTSTANDING AMOUNT _____

NOT PAYABLE AMOUNT _____

SANCTIONED AUTHORITY _____