Sedgwick
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MEDICAL INSURANCE EXPENSES CLAIM FORM

General conditions

- Complete a separate claim form for each insured person and for every visit
- Attach all diagnostic request forms, referral letter and prescription where applicable
- Original detailed account must be attached to this form
- This form must be dully completed, signed by the patient and attending Doctor
- All invoices must be signed by the patient / guardian

Name of the Employer

Name of the Employee | Staff Number

Department | Scheme Number

Patient Name | Age

Relationship with the Employee

Medical Information

(To be answered by the attending doctor)

Nature of the sickness /Diagnosis

When did the sickness start

When did the patient consult the doctor (first time)

Is the illness Congenital, Chronic /Recurring

If accident, give brief particulars

Nature of the treatment

Does the patient require any referral or specialised treatment

Member's Certificate

I hereby warrant the truth of the above statement, I have not withheld any information related to this claim and I have no objection to Sedgwick Kenya or their representative communicating with my medical provider.

Signature of Member | Date

Doctors Certificate

I hereby certify that the above amounts are in accordance with my specified treatment and to the best of my knowledge and belief. The claim is approved for payment/reimbursement.

Name of Doctor | Qualification

Date of Service | Signature | Stamp