



ইউনাইটেড ইনসিওরেন্স কোম্পানী লিমিটেড UNITED INSURANCE COMPANY LIMITED

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HEALTH PLAN - CLAIM FORM

(To be submitted at the time of making a claim- Please use block letters)

1. Name of Employer			
2. Contract Number			
3. Name of Patient			
4. Name of Employee's (in case of dependent)			
5. Relationship with the Employee			
6. Membership Number		7. Plan Type	
8. Nume of Hospital/Clinic			
9. Name of Consuliant			
10. Date of Admission		11. Date of Discharge	
12. Diagnosis			
13. Treatment			
14. Has the Patient been Discharged by the Consultant ?	Yes ☐	No ☐	
15. Total Amount of Charges	Tk.		

Signature of Employee

Date

Signature of Plan Coordinator
or Hospital Representative

Date

Reimbursement of claims can only be made when all the original documents and bills are submitted together with this Form. See overleaf

IMPORTANT

The following documents should be submitted along with this Form at the time of making a claim

1. Copy of the Consultant's recommendation for hospitalization
2. Copy of the Discharge Certificate
3. Copy of the patient's file while hospitalized (if possible)
4. Original bill of the Consultant (physician/surgeon)
5. Original bill relating to room charges, investigation and other services where applicable
6. Original bill of medicines/drugs
7. Original bill relating to surgical operation charges (operation theatre, surgical team, anaesthesia & other charges)
8. Original bill relating to ancillary services e. g. ambulance service, oxygen therapy, blood transfusion, etc.