NAIROBI
Head Office, Apollo Centre,
07 Ring, Road
Parklands, Westlands
P.O. Box 30065-00100
Tel: (+254-20) 2862000
Fax: (+254-20) 2862200
Email: info@apainsurance.org

CITY CENTRE
Hughes Building, 6th Flr
Kenyatta Ave, Nairobi
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MOMBASA
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Moi Avenue
P.O. Box 81821-80100
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KISUMU
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ELDORET
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1st Floor,
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Fax:(+254-053) 2030938
E-mail:apa.eldoret@apainsurance.org

MEDICAL INSURANCE CLAIM FORM

(N.B. 1. This form shall not be accepted unless fully completed and signed by both the doctor and the insured.
2.No admission of liability is made by insurer by the issue of this form.
3.To make a false claim is a criminal offence.

Name of Hospital/Provider: .... Tel & Fax No. ....

Name of Employer: ....

Policy /Membership No. ....

Employee's Name: .... Mobile No. ....

Patient's Name: .... Date of Birth / Age: ....

Relationship to Employee: .... ID. No. ....

Are you insured under any other medical expense scheme e.g NHIF, Workmen's Compensation, Personal Accident included?,
If so, please give particulars: ....

I .... do hereby authorize any doctor, hospital, clinic or medical provider, institution or person who has medical records or information about me and / or my family members to provide my insurer with complete information including copies of records with reference to my illness or accident, any treatment, examination, advice or hospitalisation. I have also been advised by APA INSURANCE LTD and have understood the various exclusions. Any photocopy of this authorisation shall be taken as the original copy.

Signature of Member: .... Date: ....

TO BE FILLED BY DOCTOR

Final Diagnosis of condition treated: ....

When was the condition first diagnosed: ....

Details of previous treatment for this illness / injury: ....

SICKNESS

Cause of illness/es..

Is the condition Recurrent, Chronic or Congenital? ....

Nature of treatment and given recommendations: ....

....

Does the patient require referral to a specialist? Yes / No.

If Yes, Name of Consultant .... Specialty ....

ACCIDENTS

I. Date of Accident.. Cause of Accident: ....

ii Nature of injuries..

	Kshs
Private Doctors Fees:.. =	
Prescribed Drugs .... =	
Specialist, Pathologists, X-ray & Physiotherapy fees ....=	
Total Claims..=	

I hereby confirm that the information provided above is correct and true to the best of my knowledge

Name of Doctor : ....

Telephone Number : ....

Doctor's Signature & stamp .... Date..................................