Amity Health

Medical Provider Claim Form

Provider

Provider Name : ______________________________

Patient

Cover Number : ______________________________

Patient Name : ______________________________

Date of Birth : ______________________________

Gender : ______________________________ Patient File # : ______________________________

Mobile Number : ______________________________

Chronic

Known Conditions : ______________________________

History

Medication :	
Pathology :	
Radiology :	

Encounter

Service Date	Encounter Type		Emergency		Pre Authorisation Number
	Outpatient : ☐	Inpatient : ☐	Yes : ☐	No : ☐	

Chief complaint and symptoms :

Diagnosis

Primary :	
Secondary :	

Patient Declaration

I declare that I am the patient, patient's parent or guardian (if patient's under 16 years of age) and that all information provided in the claim form is to the best of my knowledge true and correct. This declaration gives Amity the permission to get all information about my claim including, but not limited to, my current medical and previous medical providers/physician, pharmacy or any other person who has provided medical services to me or my dependants. I agree that a copy of this consent shall have the validity of the original.

Signature : ________________________________ Date : ____ / ____ / _________

Provider Declaration

I declare that all information mentioned is correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Name : ____________________________________ Tel/Fax : ____________________________________

Date : ____ / ____ / _________ Signature and stamp : _________________________

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