



P. O. Box 4251, Accra. Tel. 0302-246147. 020 0203967 Fax: 0302 246169.

INDIVIDUAL CLAIMS FORM

This form is to be fully completed and signed only by the subscribing member. Please forward your claim via your Human Resource / Admin. Department. Do not send directly to GLICO HEALTHCARE.

A reimbursable claim is one that is accompanied by all the supporting documents, and resulted from treatment that is covered on your policy but was obtained either in a true medical emergency situation , out of area network or upon the referral of your primary provider. A copy of the referral note will be required.

PATIENT DETAIL

First Name:..... Surname:

Date of Birth:..... Gender: Male Female

EMPLOYEE DETAILS

First Name:..... Surname.....

Main member Policy No.:..... Dependant Policy No.

SERVICE PROVIDER DETAILS

NAME OF CLINIC (S) WHERE TREATMENT WAS RECEIVED.....

CONSULTING PHYSICIAN..... TEL NO

SHOULD HOSPITALIZATION HAVE BEEN REQUIRED PLEASE INDICATE DURATION OF STAY

ADMISSION DATE...../...../..... DISCHARGE DATE...../...../..... TREATMENT DATE...../...../.....

DIAGNOSIS.....

CONSULTATION AMOUNT GH¢

SERVICE PROVIDED	OTHER DETAILS	COST GH¢	SUPPORTING DOCUMENT(PLEASE TICK)
LABORATORY TEST			<input type="checkbox"/> ORIGINAL RECEIPT
DIAGNOSTIC PROCEDURES/TEST(eg: CT Scan, MRI, EEG etc)			<input type="checkbox"/> PRESCRIPTION FORM
OPTICAL			<input type="checkbox"/> REFERRAL NOTE
DENTAL			<input type="checkbox"/> LAB REQUEST FORM
ANTENATAL SCREENING			
DELIVERY <input type="checkbox"/> SPONTANEOUS BIRTH <input type="checkbox"/> CAESARIAN SECTION			
CHRONIC CONDITIONS <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> HIGH CHOLESTOROL OTHER CONDITIONS			
PRESCRIBED DRUGS(ATTACH PRESCRIPTION)			

TOTAL MEDICAL COST GH¢:

PAYEE'S NAME MOBILE NO.:

EMAIL:

SIGNATURE..... DATE...../...../.....