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			☐ORIGINAL RECEIPT
DIAGNOSTIC PROCEDURES/TEST(eg: CT Scan, MRI, EEG etc)			☐PRESCRIPTION FORM
OPTICAL			☐REFERRAL NOTE
DENTAL			☐LAB REQUEST FORM
ANTENATAL SCREENING			
DELIVERY ☐ SPONTANEOUS BIRTH ☐CAESARIAN SECTION			
CHRONIC CONDITIONS ☐ASTHMA ☐DIABETES ☐HYPERTENSION ☐HIGH CHOLESTOROL OTHER CONDITIONS			
PRESCRIBED DRUGS(ATTACH PRESCRIPTION)			
TOTAL MEDICAL COST GH¢:			

PAYEE'S NAME ..... MOBILE NO.: .....

EMAIL: .....

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