Heritage Insurance Company

A member of the LIBERTY Group

BLUE

Healthcare that works where you work

www.libertyheathblue.com

MEDICAL CLAIM FORM BLUE

INVOICE NUMBER :

THIS FORM MUST BE COMPLETED FOR EVERY PATIENT RECEIVING TREATMENT. PLEASE COMPLETE A SEPERATE CLAIM FORM FOR EACH VISIT AND ATTACH YOUR INVOICE FOR PROCESSING. THE PATIENT SHOULD BE GIVEN A DUPLICATE COPY FOR THEIR RECORDS. PLEASE ATTACH DETAILED INVOICE WHERE POSSIBLE TO EXPEDITE PAYMENT. PLEASE COMPLETE FORM IN BLOCK LETTERS.

IMPORTANT: THE HERITAGE INSURANCE COMPANY KENYA WILL REJECT ILLEGIBLE OR INCOMPLETE CLAIMS

PATIENT DETAILS

FIRST NAME SURNAME

MEMBER NO DEP. CODE GENDER M F DOB. D D M M Y Y

MAIN MEMBER DETAILS

FIRST NAME SURNAME

EMPLOYER

SERVICE PROVIDER DETAILS

NAME OF CLINIC CONSULTING PHYSICIAN

LIBERTY HEALTH PROVIDER NO TREATMENT DATE D D M M Y Y

SHOULD HOSPITALISATION HAVE BEEN REQUIRED PLEASE INDICATE DURATION OF STAY

ADMISSION DATE D D M M Y Y DISCHARGE DATE D D M M Y Y

DIAGNOSIS CODING	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)
	ALLERGIC RHINITIS	J30	C-SECTION	O82	MALARIA	B54	PHARYNGITIS	J02
	ANAEMIA	D64	DENTAL CARIES	K02	MYOPIA	H52	PNEUMONIA	J18
	ANTENATAL SCREENING	Z36	DERMATITIS	L30	OPTICAL EXAMINATION OF EYES AND VISIONI	Z01	SPONTANEOUS BIRTH	O80
	BRONCHITIS	J40	DIARRHOEA/GASTRO	A09			TONSILLITIS	J03
	CANDIDIASIS	B37	GASTRITIS	K29	OTITUS MEDIA	H66	URTI	J06
	CONJUNCTIVITIS	H10	INFLUENZA	J10	PEPTIC ULCER	K27	UTI	N39
Other								

CONSULTATION	0190 - GP	0191 - SPECIALIST	11001 - OPTICAL	8101 - DENTAL	OTHER	COST	

IS THIS A MATERNITY RELATED CLAIM? ☐ Yes ☐ No

SERVICE PROVIDED	CODE	DESCRIPTION	COST
LABORATORY TESTS			
OTHER DIAGNOSTIC PROCEDURES / TESTS			
OPTICAL			
DENTAL			

PRESCRIBED DRUGS (ATTACH COPY OF PRESCRIPTION)	CODE	QTY	DOSAGE	DESCRIPTION	

PROVIDER'S DECLARATION

I CERTIFY THAT THE ABOVE PATIENT HAS RECEIVED THE SERVICES & TREATMENT NOTED ON THIS FORM, DIAGNOSED AND ADMINISTERED BY MYSELF AND THAT THIS CLAIM IS IN ACCORDANCE WITH MY SPECIFIED TREATMENT

SIGNED _____ DATE D D M M Y Y

PROVIDER STAMP

PATIENTS DECLARATION

I HEREBY DECLARE THE ABOVE STATED TO BE TRUE AND IN ACCORDANCE WITH THE MEDICAL SCHEME RULES.
I CONFIRM THAT THE DETAILS GIVEN ABOVE ARE CORRECT, THAT THE AMOUNT CLAIMED HEREIN IS NOT CLAIMABLE FROM ANOTHER SOURCE, AND THAT THE PATIENT IS A MEMBER OR DEPENDANT ON BLUE HEALTH INSURANCE. I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS TO BLUE FOR ITS CONFIDENTIAL USE AND I AGREE THAT NO AWARDS WILL BE MADE FOR THIS TREATMENT UNLESS CONTRIBUTIONS ARE RECEIVED IN RESPECT OF THE PERIOD OF TREATMENT. LIBERTY HEALTH RESERVES THE RIGHT TO RECOVER ANY AMOUNTS PAID TO PROVIDERS IN EXCESS OF BENEFITS DIRECTLY

SIGNED _____ DATE _____

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A member of the Association of Kenyan Insurers