Heritage
Insurance Company

A member of LIBERTY

The Heritage Insurance Company Kenya Limited
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Regulated by the Insurance Regulatory Authority

Claim Form — Blue

This form must be completed for every patient receiving treatment. Please complete a separate claim 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 Ltd will decline illegible, incomplete and unsigned claim forms.

Patient Details

Surname: ______ Other names ______

Member No. ______ Dep Code ______ Gender M F DOB D D - M M - Y Y Y Y

Main Member Details

Surname: ______ Other names ______

Employer / Scheme ______

Do you have any other medical insurance cover? Yes ☐ No ☐ If YES, give details: ______

Service Provider Details

Name of provider ______ Treating Doctor ______

KMPDC Reg. No. ______

Treatment date D D - M M - Y Y Y Y

Should hospitalization be required please complete a hospitalization pre-authorization form.

Diagnosis Coding

Diagnosis	Code (Tick)	Diagnosis	Code (Tick)	Diagnosis	Code (Tick)	Diagnosis	Code (Tick)
Allergic Rhinitis	J30	C-section	082	Malaria	B54	Pharyngitis	J102
Anaemia	D64	Dental caries	K02	Myopia	H52	Pneumonia	J18
Antenatal Screening	Z36	Dermatitis	L30	Optical examination of eyes and vision	Z01	Spontaneous Birth	080
Bronchitis	J40	Diarrhoea/gastro	A09			Tonsillitis	J03
Candidiasis	B37	Gastritis	K29	Otitus media	H66	URTI	H66
Conjunctivitis	H10	Influenza	J10	Peptic ulcer	K27	UTI	K27

Others (specify diagnosis)

Consultation	0190 Gp	0191 Specialist	11001 Optical	8101 Dental	Other	**Cost**	
Is this a maternity related claim?				Yes	No		

Service Provided	Code	Description	Cost
Laboratoty Tests			
Other Diagnostic Procedures/tests			
Optical			
Dental			

	Code	Qty	Dosage	Description	
Prescribed drugs (attached Copy of prescription)					

Total medical costs (*indicate currency)

PLEASE TURN TO THE NEXT PAGE AND FILL IN THE REQUIRED INFORMATION.

Provider's declaration

I certify that the above patient has received 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 Y Y

Provider Stamp

Patient / Guardian - Consent / Declaration

I ______________________ hereby declare the above stated to be true and in accordance with the medical scheme rules. I can confirm that the details given above are correct, that the amount herein is not claimable from another source, and that the patient is a member or dependant on blue health insurance. I authorize 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 un less contributions are received in respect of the period of treatment the heritage insurance company ltd reserves the right to recover any amounts paid to providers in excess of benefits directly.

Consent / Declaration

I/we consent to The Heritage Insurance Company Kenya limited:

(I) Collecting, using, disclosing and/or processing and/or storing my/our personal data for purposes that are relevant to my policy and as permitted by law;

(Ii) Collecting and sharing my personal data in accordance with the privacy statement on its website (https://www.heritageinsurance.co.ke/);

(Iii) Transferring my/our personal data to their re insurers and affiliated companies for the purposes of insurance and as permitted by law;

(Iv) And/or its contracted third parties contacting me via email/phone-call/sms/post in regard to insurance products and/or services.

I irrevocably authorize any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependents' health status to the insurer or any entity contracted by the insurer in order to fulfill its functions, duties and obligations in terms of this agreement.

I/we hereby declare the truth and correctness of the above statements and agree that this declaration shall be held to be promissory and the basis of the contract between me/ us and the heritage insurance company limited.

I/we hereby declare the truth and correctness of all the statements and particulars entered in this proposal and that i have not withheld any material information, and that my/our answers herein are in my/our full knowledge and have been written by me/us or with my/our full authority.

Signed (Patient/Guardian) ______________________

Cell Phone No. ______________________ **Date** D D - M M - Y Y Y Y