



IN-HOSPITAL CLAIM REIMBURSEMENT FORM

To be used for In-Hospital admission or Emergency Treatment

Patient's full name

Group's name, if any

Hospital's name

Hospital's location
(City & Country)

Admission date

Discharge date

Medical Reason for Admission

Total paid amount
in original currency

Total claimed amount
in US Dollars

To enclose a copy of the following:

1. Invoice
2. Receipt
3. Discharge summary from the hospital
4. Tests results
5. Detailed medical report from the Attending Physician
6. Access Card
7. Copy of Passport