Insured by

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Reinsured by

PPP HEALTHCARE

SAHA healthcare series
Claim form

You must complete sections 1, 2, 3 and 5. Your medical practitioner must complete sections 6, 7, 8 and 9 in full. Both you and your medical practitioner must sign and date this form and it must be accompanied by original receipted invoices and prescriptions or it may not be processed.

If you have any questions regarding this form or any other aspects of your cover, please telephone:
AMIG Hotline 19901 SAHA Office: 002 02 2 262 3318 SAHA Fax: 002 02 2 404 3667
Email: healthcarespecialist@amig.com.eg

Batch no:
Batch date:

1. Member's and Patient's details

Member's name	Membership number from your card	SAHA plan
Patient's name and address	Group number (if applicable)	
	Member's date of birth	
	Patient's date of birth (if different)	
	Daytime phone number	
Telephone number: Mobile number: Fax number: Email:	Patient's relationship to member	

2. To be completed by Patient (or member if patient is under 18 years of age)

1. Address to which payment should be sent.

2. Payments will be made in Egyptian pounds unless we agree otherwise in writing. In which currency was the treatment originally billed?

3. If you are claiming for treatment received outside your area of cover, please answer the following questions:

(a) Country where treatment took place

(b) The reason for the patient being abroad

(c) Dates of departure and return to own area of cover. From ________ To ________

3. Other insurer's details

Is the treatment accident-related?	Please tick ✓	Yes ☐	No ☐
Is it covered under another insurance policy?	Please tick ✓	Yes ☐	No ☐

If you have answered 'Yes' to either of these questions, please give the name of the insurance company involved.

4. Direct Settlement by AMIG

In-patient treatment must be pre-authorised by AMIG (see your handbook for details). You must contact AMIG Hotline 19901 SAHA Office: 002 02 2 262 3318 or by fax before treatment to arrange this. You are advised to confirm that written pre-approval has been received prior to undergoing treatment.

5. Patient's Declaration and Consent (to be completed by patient)

I confirm I am the patient, patient's parent or guardian (if patient under 18 years of age) and wish to claim benefit and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical practitioners involved in the patient's care to discuss treatment details and discharge arrangements with and to AMIG and/or AXA PPP healthcare. I agree that a copy of this consent shall have the validity of the original.

Signature .... Date ....

6. Medical Section (Your medical practitioner must complete sections 6, 7, 8 and 9 in full. Failure to do this may result in your claim being delayed or invalidated)

1. Medical condition requiring treatment:

2. Please give the date your patient **first** became aware of **any** signs or symptoms of the conditions being claimed for (day, month & year):

3. Please give the date on which your patient **first** presented to any doctor for this condition:

4. Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates:

5. Please give full details of any current investigations and/or treatment:

6. Please give details of any further treatment planned:

7. Laboratory or other tests required:

8. Drugs/other items prescribed. (Please list).	Dose	Frequency

9. Name of Medical Practitioner. (Please print).	Practice Stamp
10. Name of Patient receiving treatment. (Please print).	

7. Dental care (To be completed by the dentist)

Tooth no.	Description of treatment

Please tick the tooth treated in the diagram

8. Hospital or clinic information (To be completed by medical practitioner)

Hospital or Clinic name and address

Admission/treatment date	Surgery date (if any)	Anticipated discharge date

9. Medical Practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Signature .... Date ....

The claim form must be submitted within 90 days of the start date of the treatment along with all original receipts/invoices – as per the policy membership agreement. Claims will not be considered if not submitted within 90 days of treatment being received. The issue of this form does not imply any liability on the part of AMIG.

We recommend that you photocopy the completed form and any enclosures for your records.

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AMIG, AMIG, 29 El Batrawy St., Nasr City, Cairo, Egypt
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