Takaful Brunei Keluarga | Family

eKlaims

REIMBURSEMENT CLAIM FORM

(Issuance of this Claim Form does not imply acceptance of the liability)

TBK/eKlaims Member ID No. Or Patient's Member ID No. *(Mandatory)*:	Nature of Provider: [ ] Network [ ] Non Network

A. PATIENT'S DETAILS (to be completed by Patient)

1	Medical Provider Name	
2	Date of Treatment / Consultation	
3	Employee's Name	
4	Patient's Name	
6	Sex	[ ] Male [ ] Female
7	DOB (DD/MM/YYYY)	
8	Patient's IC No.	
9	Patient's Contact No.	
10	Company Name	
11	Policy No.	
12	Start Date of the Policy	
13	Nature of the Claim	[ ] Out Patient [ ] Day Care [ ] In Patient

B. MEDICAL SECTION (to be completed by the Treating Physician):

1	Chief Complaint/s (As described by Patient)		
2	Since when has the Patient been suffering from these symptoms?		
3	Diagnosis/Provisional Diagnosis		
4	Date of Diagnosis		
5	Date of First Consultation		
6	Is the present condition a complication of a pre-existing ailment/surgery (prior to the start date of the policy)	[ ] Yes, date:	[ ] No
7	Is the present ailment congenital in nature	[ ] Yes, specify:	[ ] No
8	Is the present ailment job-related	[ ] Yes, specify:	[ ] No
9	Is the ailment maternity related	[ ] Yes, specify:	[ ] No

C. CLAIM SECTION *(ITEMIZED ORIGINAL RECEIPTS & APPLICABLE PRESCRIPTIONS / REPORTS / RESULTS MUST BE ATTACHED TO CONSIDER CLAIM)* (to be completed by the Treating Physician):

1	Consultation Cost	
2	Laboratory Cost	
3	Pharmacy Cost	
4	Physiotherapy Cost	
5	Radiology Cost	
6	Inpatient Cost	
7	Total Claimed Amount	

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

Medical Practitioner's Name, Seal & Signature

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*Registration No. :*_______________________________________

Telephone No. : _______________________________________

Fax No. : _______________________________________

I confirm that I am the patient/patient's spouse or guardian (if patient is under 18 years of age) & declare that all the particulars given above are to the best of my knowledge true & correct. I hereby authorize any Medial provider, Insurer, Employer or any other Organization to release any information regarding my medical condition & history to Takaful Brunei Keluarga / Family or eKlaims for the purpose of determining insurance benefits. I agree that a copy of this consent shall have the validity of the original.

Signature: ___________________________

Date: ______/______/______