ድርጅት ሕ ወት ዐብ ቅርንጫፍ
ምና ካሣ መጠየቂክ ቅጽ

ማሳሰቢክ:- የቅጹን ክፍል 1 ብቻ ባ በ ች በመሙላት ተገቢውን የህክምና ማስረጃ ች ክክ ፦:: ሰነ ቹ የ ካሚውን ስም፣ የሕክምና ቀን፣ የበሽ ው ዓ ነትና የመሳሰሉት ለካሣ ክፍክው አስ ሳጊ የሆኑ መረጃ ች መክ ቸውን አረጋግጠው ክቅርቡ::

NOTE:- PLEASE COMPLETE PART 1 OF THIS FORM AND ATTACH MEDICAL CERTIFICATE, PRESCRIPTIONS AND RECEIPTS, PAYMENTS ARE SUBJECT TO THE CORRECTNESS OF INFORMATION LIKE NAME OF PATIENT, DATE OF TREATMENT, DIAGNOSIS ETC.

PART I

የውሉ ቁጥር
POLICY NO. __________________

የውለ ባለቤት
POLICY OWNER _______________

የ ካሚው ስም
NAME OF PATIENT _____________________

______________________ ________________________
DATE SIGNATURE

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FOR E.I.C OFFICE USE ONLY

PART II

PERIOD OF INSURANCE:- FROM_________________ TO _______________

CLAIM NO. _________________ MEMBERSHIP NO. _____________

PART III

	I T E M	AMOUNT	DEDUCTION
A	SURGEON'S & ANESTHETIST'S		
B	SPECIALIST AND PATHOLOGIST		
C	HOSPITALS AND NURSING HOME		
D	LAB, X-RAY, ELECTICAL MASSAGE		
E	SURGICAL APPLIANCES		
F	MEDICENS & DRUGS		
G	DOCTOR'S FEE		
H	EYE GLASS		
I	DENTAL FILLINGS		
J	OTHERS		
	TOTAL í í í í í ..		

PREVIOUS CLAIM EXPENSES (BIRR) _______________ LESS EXCESS ____________

NET PAYABLE IN FIGURE ____

NET PAYABLE IN WORDS ____

PREPARED BY __________CHECKED BY ____________APPROVED BY _________

DATE __________ DATE ____________ DATE __________