TTARP

TTARP Medical Insurance Claim Form

Please submit this form to TTARP's head office within ninety (90) days of treatment.

1. **Name: .....**
2. **Date of Birth: .....**
3. **Name of attending Physician/s: .....**
4. **When did symptoms of this ailment first appear or accident happen?.....**

   .....

   .....
5. **Have you ever had this ailment before? .....If YES, state when and describe: .....**

   .....

   .....
6. **Are you covered under any other GROUP Insurance Plan providing benefits for this ailment?... If YES, give:**

   (a) Name of Insurance Company: .....

   (b) Name of Group or Company insured under: .....
7. **Statements/bills for the following expenses are attached in support of my claim:** ***(Please tick appropriate box)***

☐ **Hospitalisation**	☐ **X-Ray**	☐ **Drugs**	☐ **Specialist Consultations**
☐ **Surgery**	☐ **Lab Test**	☐ **Injections**	☐ **Other Treatment/Service**

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorise all Doctors who treated me and all Hospitals or Institutions to furnish full information as requested by M&M INSURANCE BROKING SERVICES LIMITED for the purpose of settling this claim.

Date: ...../...../..... **Signature: .....**
DD MM YYYY

Official Use Only

Date Received:.....

Membership Status: .....

Health Plan Status: .....

ATTENDING PHYSICIAN'S STATEMENT

Please complete this form and give to your patient.

GENERAL

Name of Patient: Age:

Address:

Name of Insured Person:

Address:

DOCTOR'S VISITS

Date of Visit or Service	DIAGNOSIS (Describe complications, if any)	TYPE OF VISIT			Cost of Visit $	SERVICE RENDERED (If controlled Drugs supplied, please specify trade names)	Cost of Service (if any) $	FURTHER SERVICES RECOMMENDED (Referrals confinement, etc.)	Doctor's Signature
		Home	Hospital	Office					
				TOTAL: $			TOTAL: $		

Certified Specialist ❑ Yes ❑ No

SURGICAL OPERATIONS

Describe Procedure/s Performed (Describe complications, if any)

Date of Surgery: ...../...../..... (DD MM YYYY)

Surgery Time:

Surgery Fee: $

Anaesthetic Fee: $

MATERNITY

Date Pregnancy Commenced: ...../...../..... (DD MM YYYY)

Date of Delivery: ...../...../..... (DD MM YYYY)

Obstetrical Fee: $

REMARKS

Please supply Information relevant to any charges in excess of the normal and customary levels: