

ድርጅት ሕብረት ዐብ ቅርንጫፍ ምና ካሳ መጠየቂያ ቅጽ

ማሳሰቢያ:- የቅጹን ክፍል 1 ብቻ ባ ሰ ሰ ቅ ስመሙላት ተገቢውን የህክምና ማስረጃ ቅጽ ክክቅጥ:: ለነ ቹ የ ካሚውን ስም፣ የሕክምና ቀን፣ የበሽ ው ዓቅነትና የመሳሰሉት ለካሳ ክፍክው አስቅላጊ የሆኑ መረጃ ቅጽ መክቅቸውን 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
í í

FOR E.I.C OFFICE USE ONLY

PART II PERIOD OF INSURANCE:- FROM _____ TO _____ CLAIM NO. _____ MEMBERSHIP NO. _____

PART III

	ITEM	AMOUNT	DEDUCTION
A	SURGEON'S & ANESTHETIST'S		
B	SPECIALIST AND PATHOLOGIST		
C	HOSPITALS AND NURSING HOME		
D	LAB, X-RAY, ELECTRICAL 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 _____