Medical Claim Reimbursement Form

PRUDENTIAL
Prudential Assurance Uganda Limited.
P. O. Box 2660 Kampala, Uganda.
Tel: +256 414 343 897/909.
Toll Free no. 0800343897
E-mail: caremanagement@prudential.ug
www.prudential.co.ug

▶ Complete the form in CAPITAL LETTERS.

1. Claims should be submitted within 30 days from the date they are incurred. This is a policy requirement. Claims submitted after this period will not be honoured.
2. Did you seek Authorisation? If yes indicate authorisation code……..
3. Standard requirements/ documentation for all claims are:
   a) Outpatient claims- Medical Report or Lab request form or Prescription note and itemised receipt,
   b) Inpatient claim form duly filled receipts & supporting invoice, discharge summary, or medical report as may be required.

EMPLOYEE'S SECTION (*All Fields are Mandatory) – Not required if submitting the claim directly on e-Services

Patient Name: _____

Date of birth of Patient D D M M Y Y

Patient's Membership No: _____

Scheme /Company Name: _____

Employee Name: _____

Mobile No: _____

Email: _____

Address: _____

REIMBURSEMENT METHOD (Tick either fields and fill the details below)

Bank Name: _____

Bank Branch: _____

Account Name: _____

Account No.: _____

Total Amount Claimed _____ Currency _____

Investigations, Medical Service provided, Drugs: (please attach a copy of the Prescription, Lab Report, Invoice etc.)

OPD ☐ ADMISSION ☐ DENTAL ☐ OPTICAL ☐

Did you seek Authorisation for this claim? YES ☐ NO ☐ (Please tick)

Reason for Reimbursement? _____

_____

AUTHORIZATION STATEMENT

I declare that the details given on this form, including the fees charged, are true and accurate and that i have not missed out any details. important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that will invalidate the plan and make me liable to prosecution. For this medical claim, I authorise any Medical Practitioner, Specialist, Consultant, Therapist or other relevant establishment who has attended to me/the patient, in the past or is attending to me/the patient at present, to give details that may be asked for by Prudential Assurance Uganda Limited.

DISCLAIMER

- I hereby authorize Prudential to wire transfer claim reimbursements to the account indicated above. This agreement will remain in effect until I give written notice when refunds are received. I authorize Prudential to revise the Transaction and withdraw the overpayment.
- I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company.

Employee's Signature _____ Date D D M M Y Y Y Y

OFFICIAL USE ONLY

Amounts Payable: _____

Verified By: _____ Signature: _____ Date: _____

Authorised By: _____ Signature: _____ Date: _____

TERMS AND CONDITIONS

Decisions on coverage will be reviewed and confirmed based on the policy, guidelines and agreements in place. Coverage means either the determination of:

1. Whether or not the particular service or treatment is a covered benefit under the terms of the particular member's benefits plan

2. Where a physician or health care professional is providing a service that is necessary and is payable under the terms of the provider agreement.

3. Whether the physician or health care professional is on outside of our panel and has received authorisation to offer the services.

4. Whether the physician or health care professional is offering a service that is priced within our customary and reasonable rates.

5. Where a physician or health care professional is providing a service that is within their scope or profession.

6. Exclusions will be taken into consideration. These will be deducted on the amount claimed.