FAIRFIRST INSURANCE LIMITED
(Company No. PB 5180)
Access Towers II (14th Floor), No. 278/4, Union Place, Colombo 02, Sri Lanka.
Tel: 011-2428428 Fax: 011-2438438
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Medical Claim Form

Cashless Hospitalisation Claim Request Form

This claim form is not an admission of liability.

Please use a separate claim form for each separate admission.

Part I. To be completed by the Policyholder

Important notes:

a. This form is to be completed by the Policyholder
b. To enable us to process your claim promptly, please ensure that the form is fully completed
c. We reserve our rights to request additional information or documents if needed
d. If you have any questions regarding this form or any claims matters, please contact our Customer Care Centre 0112428428 quoting your policy/membership number/Employee ID (EPF Number)
e. Send this claim form together with all supporting documents to **worldwidehealth@fairfirst.lk** or reach out to us on 0112428428

A. Administrative

Policyholder:		Policy number:	
PATIENT'S DETAILS			
Patient name:		Date of birth: dd / mm / yyyy	
ID/Passport number:	Nationality:	Gender: (M/F)	
Email address:		Contact number:	

B. Patient/Policyholder Declaration

I hereby confirm:

a. That I authorize the Physician, Hospital/Clinic or any other medical institution to give the information and/or medical record, according to the diagnosis and/or medication treatment given to my family or me as the Insured.
b. That I authorize a Fairfirst representative and its designated third-party administrators to gather further information/medical records from the Hospital and/or other parties related to the diagnosis and/or health services provided to me or eligible members of my family which may be required to process the claim in accordance with the existing policy conditions.
c. That all information on this Reimbursement Claim Form (In-Patient) was written truthfully and I hereby agree that this Letter of Authority to be used promptly.
d. That the copy of this Declaration is valid and has power in accordance with the original document.
e. That I authorize my Financial Advisor/Agent or Insurance intermediary to discuss medical conditions as necessary with my Insurer or its authorized Insurance intermediary on my behalf.
f. That I am the patient/the patient's parent or guardian if the patient is under 18 years of age.

Patient/Policyholder signature: Date:

Part II - To be completed by the Medical Practitioner at the Policyholder's expense

Important note:

a. Part II of this form is to be completed by the Medical Practitioner.
b. To enable us to process the Life Assured's claim promptly, please ensure that the form is fully completed.
c. We reserve our rights to request additional information or documents if needed.

C. Medical Section (Section C to be completed by the Medical Practitioner)

Symptoms presented:	Date the patient first became aware of any signs or symptoms of this condition: dd / mm / yyyy	Date the patient first presented the condition to a doctor: dd / mm / yyyy
Physical findings:	Vital signs: Pulse: BP:	Temp: Resp:
Provisional diagnosis/condition:	Final diagnosis:	
If there are symptoms presented, please advise: a) How long has the symptom(s) existed prior to consulting you?	b) When did the symptoms first start?	
If there is no symptom presented, what prompted the patient to see you?		
In your expert opinion, given the etiology of the condition, how long do you think the condition has been present?		

Investigation (describe the necessary investigation requested/required to define the diagnosis):

Was the patient referred to you by another Medical Practitioner? □ Yes □ No

If "Yes", please provide the name of the referring Medical Practitioner & contact details.

Does the patient have any related medical condition? □ Yes □ No

If "Yes", please state and explain the relation.

Does the patient suffer from other significant medical condition(s)? □ Yes □ No

If "Yes", please state the medical condition(s) and the date of diagnosis.

Medical Condition	Date of Diagnosis	Treatment Given

Has the patient received any previous consultation/treatment/hospitalisation for this condition, associated conditions or symptoms and/or other conditions? □ Yes □ No

If "Yes", please provide details.

Date of Treatment	Medical Condition	Name and Address of Doctor

Is the condition/treatment/surgery related to any of these?

If "Yes", please tick.

□ Pregnancy or childbirth
□ Congenital anomaly
□ Abortion or miscarriage
□ Genetic or chromosomal disorder
□ Infertility or sub-fertility condition
□ Mental or psychiatric condition
□ Sexually transmitted disease
□ Cosmetic reason

If the claim is related to pregnancy, was pregnancy conceived from natural conception? □ Yes □ No

Is the medical condition/injury caused by an accident? □ Yes □ No

If "Yes", please tick.

□ Road traffic accident □ Work related accident □ Others: _____

Please describe how the accident occurred? State date/time of the accident and cause of accident.

D. Further Treatement Plan

Please give details of any further treatment plan:

E. Medical Practitioner's Declaration

I hereby certify that I have personally examined and treated the Patient in connection with the above condition and that the facts as given above present my opinion of his/her condition. I declare that the information provided on this form are true and accurate and I did not withhold any material information.

Name of Medical Practitioner: Date:

Signature of Medical Practitioner: Hospital/Clinic stamp

Email us : worldwidehealth@fairfirst.lk or Call us 0112428428