



NATIONAL CLAIM & APPROVAL FORM (DENTAL & OPTICAL) Sr. No.

SECTION A: TO BE COMPLETED BY MEMBER

Member Name: [] M [] F []
Policy Number: [] ID. Number: []
D.O.B [] File No. _____ Mob. No. _____ Date of Visit: ___ / ___ / ___

SECTION B: TO BE COMPLETED BY DENTIST

1. Chief Complaint & Main Symptoms:
2. Duration of illness
3. Diagnosis.....
4. Please tick ([x]) where appropriate:
[] RTA [] Work Related Accident [] Sports Related [] Cleaning
[] Orthodontics\Esthetics [] Congenital/Developmental [] Check-Up
5. Anticipated plan of treatment/procedures

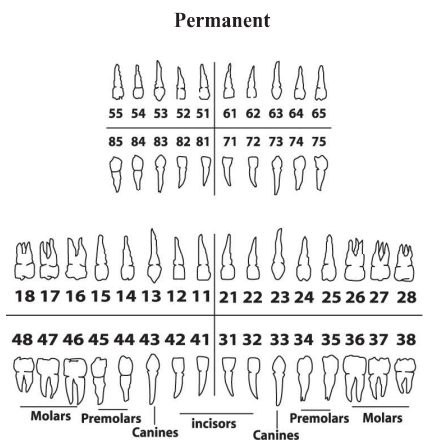


Table with 2 columns: Service, Cost. Rows include Doctors Fee, Medicine, X-Ray, Dental procedures (specify).

Anticipated Total Cost [] Anticipated Date of Rx []

SECTION C: TO BE COMPLETED BY OPHTHALMOLOGIST/OPTICIAN

Table for eye examination with columns for RIGHT EYE and LEFT EYE (Sphere, Cylinder, Axis, Prism, V/A) and rows for Distance, Near, Right Lens Cost, Left Lens Cost, Frame Cost, Anticipated Total Cost.

SECTION D: DECLARATION TO BE SIGNED BY ATTENDING PHYSICIAN AND THE MEMBER OR GUARDIAN

I hereby certify that ALL information mentioned herein are correct & that the services shown on this form were medically indicated & necessary for the management of this case.
Name of Physician:
Signature:
Stamp & Licence No: _____ Date: / /

I, the undersigned, hereby declare that the above mentioned services have been rendered to me in full and confirm that the settlements contained herein are true and that all relevant information has been disclosed.
I hereby authorize my insurer/TPA to review my file if any further information or clarification is required.
The receipt of this claim form/ other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
Member Signature _____
(Date of completion of treatment: / /)

FOR INSURANCE COMPANY USE ONLY:

[] Approved [] Not Approved Comments:
Approved No.: Approved Validity :
Insurance Officer: Signature: Date: / / CLAIM No. []