Amity Health

Medical Provider Claim Form

Provider

Provider Name : _____

Patient

Cover Number : _____
Patient Name : _____
Date of Birth : _____
Gender : _____ **Patient File # :** _____
Mobile Number : _____

Chronic

Known Conditions : _____

History

Medication :	
Pathology :	
Radiology :	

Encounter

Service Date	Encounter Type		Emergency		Pre Authorisation Number
	Outpatient :	**Inpatient :**	**Yes :**	**No :**	

Chief complaint and symptoms :

Diagnosis

Primary :	
Secondary :	

Patient Declaration

I declare that I am the patient, patient's parent or guardian (if patient's under 16 years of age) and that all information provided in the claim form is to the best of my knowledge true and correct. This declaration gives Amity the permission to get all information about my claim including, but not limited to, my current medical and previous medical providers/physician, pharmacy or any other person who has provided medical services to me or my dependants. I agree that a copy of this consent shall have the validity of the original.

Signature : _____ Date : ____ / ____ / _____

Provider Declaration

I declare that all information mentioned is correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Name : _____ Tel/Fax : _____

Date : ____ / ____ / _____ Signature and stamp : _____