Umoyo Health Care Insurance

Payment Claim Form (C1)

Off Zalewa Road,

P.O. Box 1772, Blantyre. Tel: +265995408448

Website: www.uhci.mw

SECTION A (1 – 4)

DATE _____/_____/_____

1. Service Provider Details			
Name Of Facility			
Registration No.			
Address			
Phone Contact		Email address	

2. Patient Details			
First Name		Last Name	
ID No		UHCI card No.	
Date of Birth		Gender	
Phone No.		Email	

3. Principal Client Details (if dependent patient only)					
First Name			Last Name		
Workplace			Phone Contact		
Address					
Type of Scheme (Cover)	Platinum	Gold	Siler	Emerald	Blue

4. Clinic/Hospital/Doctor Visit				
Main Cause of hospital visit today	Illness <3 days	Illness >3 days	Review	Injury
last Hospital/clinic visit	N/A	<30 days	30-180 days	> 12 months

SECTION B

5. Diagnosis Details	
	ICD 9/10

6. Claim Details				
	Description of procedure	CODE	QTY	COST
1				
2				
3				
4				
5				
6				

7. Service Provider Details			
Name Of Facility	Provider/Facility/ UHCI Code	Consulting Clinician	Date of Consultation

8.Patient Full Name:		**Signature**		**Date**	/. /

I confirm to the best of my knowledge the patient treated and named in this form. I agree that any claim for service not provided would be regarded as fraudulent and may result in deregistration of the health facility/litigation or both.

8. Authorizing Details				
Full Name		**Title**	MCM Reg. No.	
Signature		**Date**		
Invoice No.				