REFUND CLAIM FORM

Maisha Health Fund

Service Provider

Employer/ Account Holder

Date D D M M Y Y Y Y

Patient's Details

Surname

First Names

Gender ☐ Male ☐ Female

Date of Birth D D M M Y Y Y Y

Relationship to Member

Member Number

Patient's Suffix

Medical Claim Details

	EXPENSE TYPE	DAY	MTH	YR	MEMBER'S SIGNATURE	QUANTITY	AMOUNT
1							
2							
3							
4							
5						TOTAL CLAIM	

Expense Type: e.g. Prescription Drugs, X-ray Service

Member's Signature.....

Date D D M M Y Y Y Y

NB: Please attach receipt, claim form from service provider and prescription where applicable

Name of Member:.....

Membership No:.....

Bank: .....

Branch:.....

Branch Code:.....

Account Name

.....

Account Number

.....

Physical Address:.....

Contact Person:.....

Signature .....

Contact Number.....

FOR OFFICIAL USE ONLY

Members Limit

Excess

Claim Authorised by:

Date D D M M Y Y Y Y

Claim Processed by:

Date D D M M Y Y Y Y