Doc. No. ASSEMBLE/R/37

ASSEMBLE INSURANCE
Plot No. 74, Serengeti Rd / Warioba Street
Mwai Kibaki Rd, Mikocheni
P.O.Box 9600 Dar es Salaam, Tanzania
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Email: info@assemble.co.tz

Assemble INSURANCE
Your Future is Protected

PREFERRED PROVIDER CLAIM FORM

Serial No. 163501

NB: PLEASE COMPLY WITH THE FOLLOWING / TAFADHALI TIMIZA YAFUATAYO

- **Complete a separate Claim form for each member and for every visit / Jaza fomu hii kwa kila mgonjwa na kwa kila hudhurio**
- **Ensure the ailment doe not fall under excluded conditions / Hakikisha ugonjwa haupo katika Magonjwa ambayo hayahudumiwi.**
- **For exclusions, terms and conditions, see overleaf/ kwa magonjwa ambayo hayahudumiwi na maelekezo zaidi, geuza karatasi hii.**

_____ Date _____

ADDRESS: _____

AGE: _____ SEX: _____

PATIENT'S NAME/ JINA LA MGONJWA _____ M/SHIP NO./NA YA UANACHAMA _____

EMPLOYER / MWAJIRI _____

RELATIONSHIP WITH PATIENT / UHUSIANO _____ TEL: _____

PATIENT'S COMPLAINT(S) / MALALAMIKO YA MGONJWA 1. _____ 2. _____ 3. _____

DURATION SINCE ONSET / MUDA TANGU UGONJWA KUANZA _____

EXAMINATION FINDING / MATOKEO YA VIPIMO 1. _____ 2. _____ 3. _____

DIAGNOSIS / MARADHI (CODE): _____

TREATMENT GIVEN / MATIBABU (Include specifed dosage & Quantity)	TSHS
1	
2	
3	
4	
TOTAL	

LABORATORY TEST / VIPIMO VYA MAABARA	TSHS
1	
2	
3	
4	
TOTAL	

ANY OTHER PROCEDURE DONE (CLEARLY SPECIFY e.g CHEST-X-RAY) HUDUMA NYINGE YOYOTE (ELEZA WAZI K.M. PICHA YA KIFUA)

_____

_____

CONSULTATION FEE / ADA YA KUONANA NA DAKTARI _____

SEEN BY / AMEONWA NA ☐ Specialist / Bingwa ☐ G.P.(MO) ☐ AMO ☐ CO

DOCTOR'S SIGNATURE _____

By Signing below I hereby consent to ASSEMBLE contacting my doctor or medical institution to obtain medical information about me and I hereby authorize such doctor or institution to make full disclosure of information to ASSEMBLE or its advisors, and to provide access to my complete medical and hospital records whenever required.

MEMBER / GUARDIAN SIGNATURE (FOR A DEPENDANT) / SAHIHI YA MGONJWA _____

PLEASE FORWARD THIS FORM FULLY COMPLETED TOGETHER WITH YOUR INVOICES(S) WITHIN 30 dAYS OF ATTENDING TO THE PATIENT. PAYMENT WILL BE MADE IN 30 DAYS FROM THE DATE OF RECEIPT OF THE FULLY COMPLETED FORM AND INVOICES (S)