REIMBURSMENT CLAIM FORM

RESOLUTION INSURANCE

Claim Ref. No.

HEAD OFFICE: Parkfield Place, Muthangari Drive, Off Waiyaki Way, Westlands
P. O. Box 4469 - 00100, Nairobi, Kenya | Tel: +254-20-2894 000
Mobile: +254-709-990 000, +254-730-199 000
Pre-Authorization Tel: +254 20 2894 222, +254 720 756 000, +254 734 828 812
Email: care@resolution.co.ke

1. **Patient Must Complete Section A, B and D**
2. **The Attending Doctor Must Complete Section C**
3. **Claims Should Be Submitted Within 30 Days**

A. PERSONAL DETAILS

Name of Patient: First Name | Middle Name | Last Name

Membership Number | D.O.B: D D M M Y Y

Name of Principal Member: First Name | Middle Name | Last Name

Principal Member's Employer: Company Name

B. DETAILS OF ILLNESS

Date of first onset of symptoms: D D M M Y Y

Date of first consultation with doctor: D D M M Y Y

DECLARATION

I hereby declare the above statements to be true and complete. I also consent to Resolution Insurance Company Limited seeking further information from any medical institution or doctor whom my dependants or I have consulted.

Date: D D M M Y Y Signed: _____ Member / Guardian

C. DIAGNOSIS _____

_____

Doctor's Name: _____

Date: D D M M Y Y Sign & Stamp: _____

D. BANK DETAILS (Indicate the principal member account details)

Account Holder's Name: First Name | Middle Name | Last Name

Bank Name: Branch:

Account Number: Account Holder's Relation to the Claimant: _____

E. REIMBURSEMENT CHECKLIST

The following are **Mandatory** for prompt claims settlement:

- ☐ Original Payment Receipts
- ☐ Itemized Bill
- ☐ Duly signed and stamped Medical Report / Discharge Summary **(for Inpatient ONLY)**
- ☐ Bank Details
- ☐ Narration (if treated by provider on the RIL panel)

Kindly contact me for the refund on Telephone: **Email:** _____

NB: A duly filled reimbursement claim form with all mandatory documents should be submitted to the claims department within 30 days.