HEALTH INSURANCE
SERVICE PROVIDER CLAIM FORM

PARNELL
Assurance PNG

Attending Physician Section (Mandatory fields marked with an asterisk*)

To be completed by attending physician

Employer Name:*			
Member/Employee's full name:*			
Patients Full Name:*		Patients D.O.B (dd/mm/yyyy):*	
Chief Complaints:*			
Diagnosis:*			

How long has the patient been suffering from this sickness?*

If treated by another medical service provider please specify the name:

Details of treatment (other than prescription):

If further treatment or operative procedure anticipated, please provide the details below:

Physician's Name:*	
Physician's Signature and stamp:*	

Claim attachments checklist

Required	Documents	Notes
Yes	Claim form (with completed physician section)	Fully completed and signed by you and your physician/surgeon
Yes	Original hospital/clinic bill	Signed and stamped by appropriate SP staff
If applicable	Detailed medical report	Detailing ailment/diagnosis or accident with dates it started/ happened, signed by your treating physician
If applicable	Copy of lab tests and reports	Only related to this incident

Please remember: To help us process your insurance claim as quickly as possible, we ask you to provide the above documents. Otherwise your claim could be delayed or potentially rejected.