GROUP OUTPATIENT & DENTAL BENEFIT CLAIM FORM
PT AVRIST ASSURANCE

avrist
Advancing Life

Directions:
1. This Form shall be filled by Patient/Insured* and the doctor who treats and one claim form can only be used for ONE patient.
2. Original receipt and the copy of prescription costs paid shall be attached and completed with the treatment date, patient's name, diagnose, stamp and signature of the doctor who treats the patient.
3. Claim of expense in purchasing medicine and/or claim of X-ray examinations/ laboratory tests shall be supported by prescription or recommendation from the doctor who treats the patient and invoice /receipt from the pharmacy laboratory must be original.
4. Claim of the treatment expenses must be submitted within 90 (ninety) days since the treatment date.

A. FILLED COMPLETELY BY PATIENT/INSURED*

Company's Name

Employee's Name

Patient's Name (if not the employee/member)

Gender ☐ Male ☐ Female

Policy No.

Membership No.

Relationship Between Patient/Insured and Employee

Birth date ☐☐ - ☐☐ - ☐☐☐☐
DD MM YYYY

*) If the age of Patient/Insured is below 18 years old, this form shall be filled by the employee.

I, as the patient of hospital/clinic, hereby irrevocably and without any coercion from any party whomsoever, declare as follows :
1. I authorize Avrist Assurance with right of substitution to obtain all information/medical record from hospital/other party relating to diagnose and or medical treatment provided to Me according to the prevailing regulations. I waive provisions stipulated under Articles 1813, 1814 and 1816 of Indonesian Civil Law Code regarding the termination of authorization.
2. Authorization provided by Me under this Group Outpatient & Dental Benefir Claim Form, either the original as well as its copy, has the valid legal power.
3. All information mentioned in Group Outpatient & Dental Benefit Claim Form are complete and accurate and hereby understand and agree that Avrist Assurance may reject the claim submitted by Me in this Form if any information and statement provided by Me or Doctor in this Form are known incorrect and inaccurate by Avrist Assurance.
4. I have full right and entitlement to provide statement and authorization mentioned in this Group Outpatient & Dental Benefit Claim Form.

Patient's/Employee's signature and date of treatment

B. PLEASE FILL COMPLETELY BY DOCTOR WHO PROVIDES TREATMENT

Doctor's Name :

Anamnesis :

Physical Examination :

Diagnose (please use capital letters) :

ICD X Code

DD/ :

Supporting Exam / Laboratorium :

Suggestion :

Therapy (Prescription Copy) :

Address of Clinic/Hospital

Telephone/Mobile No.

Diagnose for Dental Treatment

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

I hereby declare that my written statements above are true and complete and hereby understand and agree that Avrist Assurance may reject the claim submitted by Me in this form if any information and statement provided by Me in this Form are known incorrect and inaccurate by Avrist Assurance.

ATTENTION:
Form MUST be filled completely. Otherwise, the claim process will be suspended.

Doctor's Signature and Signature Date
Hospital Stamp/Clinic