



Premiermedicaid

NIGERIA LIMITED

(HEALTH MAINTENANCE ORGANISATION- HMO)
NATIONAL HEALTH INSURANCE SCHEME

E-mail Address:- info@premiermedicaid.com.ng

FORM PMC / 001

1 June, 2007

CLAIMS FORM

Name of Provider: _____ Registration No: _____

Name of Patient: _____ Age: _____ PIN: _____

Date of Notification: _____ Date of Admission _____ Date of Discharge _____

Diagnosis _____ Authorisation Code: _____

DETAILS OF TREATMENT			COST (₦)
E-mail _____			
Accommodation ₦ _____ for _____ days			
Feeding at ₦ _____ for _____ days			
Drugs/Infusion	Dosage	Duration	
Investigations and results (Pls specify): _____			
Professional Fees: _____			
Total ₦			

.....
Patient's Signature

.....
Doctor's Signature

Name: _____
Employer: _____
GSM: _____

Name: _____
Address: _____
MDCN: _____
GSM: _____