SOLARELLE HEALTH INSURANCE CLAIM REIMBURSEMENT FORM

(Claims will not be settled unless the claim form is duly completed and signed)

NAME OF THE STAFF:

MEMBER / STAFF ID:

DEPENDENT NAME: (IF BEING SUBMITTED)

NATIONAL ID/ PASSPORT NO:

COMPANY NAME:

CURRENCY (USD/MVR)- PLEASE SPECIFY:

BANK NAME:

BRANCH/ COUNTRY:

BANK ACCOUNT NAME:

BANK ACCOUNT NUMBER:

CONTACT NO:

EMAIL ADDRESS:

#	PATIENT NAME/CLAIMANT	STAFF/ DEPENDENT	DATE OF TREATMENT	PRESCRIPTION	BILLS	AMOUNT	
					TOTAL		

Employee's Signature: …… **Date……**

Please attach prescriptions/ discharge summaries/ memos/ requisitions and bill receipts for each item