TO BE COMPLETED BY THE DOCTOR

atlantic
INSURANCE

CLAIM NO: .....

15 Esperidon Str., 2001 Strovolos
P.O.Box 24579, 1301 NICOSIA
Tel.: 22886000, Fax.: 22886111

OUTPATIENT CLAIM FORM

Company's Name: ..... Policy No.: .....

Patient's Name: ..... Insured Code.: .....

Address: .....

..... Tel. & Fax: .....

The above patient visited my clinic on the ..... and was

suffering from .....

.....

I have advised the following diagnostic tests & medications

(a) Radiology ..... (c) .....

(b) Laboratory ..... (d) .....

No.	Description of Drugs

Date: .....

Doctor's Fee: .....

Doctor's Name: .....

Doctor's Tel. No.: .....

.....
INSURED'S SIGNATURE

.....
DOCTOR'S SIGNATURE & STAMP

This form must be accompanied with all relevant original receipts, invoices & reports