APA OPTICAL CLAIM FORM

Name of Hospital/Provider: …… Tel & Fax No…….

Name of Employer: ……Policy/Membership No. ……

Employee's Name:……. Tel/Mobile No. ……

Patient's Name: ……..… Date of Birth/Age: ……

Relationship to Employee: …… I. D. No……

I hereby declare that all the statements given by me on this form are to the best of my knowledge true and complete. I declare that I have been shown the amount applied for pre-authorisation, and have been provided with products to the value indicated on this form. I authorise the Insurance Company to obtain medical information from the doctor I have consulted and shall submit to any medical examination(s) if so required by the Company.

Signature of Member:…… ID No.:……

Date:……

TO BE FILLED BY DOCTOR

Final Diagnosis of illness Treated: ……..…

Nature of treatment given and recommendations:……..…

1. Prescription Details

New Prescription: **Old Spectacle Prescription (If different)**
Date of Last Replacement:……

Eye	Sphere	Cylinder	Axis	Addition		Eye	Sphere	Cylinder	Axis	Addition
RE						RE				
LE						LE				

2. **Spectacles are for (tick one):** ( ) Correction Of Sight ( ) Light Sensitivity

3. Reason For New Spectacles (tick as many as apply)

			Kshs
First time vision correction	( )	**Consultation Fees**	……
Prescription change	( )	**Frames**	……
Frame wear and tear	( )	**Lens**	……
Frame breakage beyond repair	( )	**Others**	……
Lenses broken or scratched	( )		
Spectacles lost	( )	**Total**	……
Patient Request	( )		
Other	( )		
(Please fill)……			

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: …… Doctor's Signature & Stamp: ……..…

- **Note Exclusions: Plano prescriptions, disposable contact lenses Photochromatic and anti glare lenses, Designer frames and lenses are not covered**

Apollo Centre, No 7 Ring Road Parklands, P O Box 30065, Nairobi 00100, Kenya
Tel: 254 (0) 20 286 2000 Fax: 254 (0) 286 2200 E-mail: info@apainsurance.org Website:www.apainsurance.org