NONSUCH

Health Maintenance Organization

Nonsuch Medicare Limited RC 684109

CLAIMS FORM FORM 006

Name of Provider…… Registration No……

Name of Patient: …… Age: ……. IDNo: ……..

Date of Notification: …… Date of Admission: …….. Date of Discharge: ……

Diagnosis: ……

DETAILS OF TREATMENT			COST(N)
Accommodation N: …… for…… Days Feeding at N: …….. for …….. Days			
Drugs/Infusion	Dosage	Duration	
Investigations and results (Pls specify): …… …… …… Professional Fees:			
		TOTAL:	

_____ _____ _____

Sign. of Provider Sign. Of Patient Sign. of Nonsuch Officer