MEDICARE

ZENITH MEDICARE LIMITED

CLAIMS FORM

Health Care Provider: _____ Provider ID: _____

Name of Enrollee: _____ Enrollee ID: _____ Age: _____ Sex: ____

Date of Service: _____ Date Of Admission: _____ Date Of Discharge: _____ Diagnosis: _____

DETAILS OF TREATMENT					TOTAL COST (N)
Accomodation N: _____ For _____ days					
Feeding at N: _____ For _____ days					
Drugs/ Infusion	Dosage	Duration	Market Cost	Mark Up	
Procedure and Outcome (Please Specify) _____					
Investigations and Result (Please Specify) _____					
				TOTAL (N)	

Signature Of Provider

ZENITH MEDICARE LIMITED.65, USUMA STREET, MAITAMA, ABUJA.TEL:09-4133870-1. FAX: 09-4131660. e-Mail:info@zenithmedicare.com. website:www.zenithmedicare.com

Enrollee's Signature