m-tiba carepay

M-TIBA OUTPATIENT CLAIM AND PRE-AUTHORIZATION FORM

HEALTHCARE PROVIDER NAME AND BRANCH (IF APPLICABLE)

PATIENT DETAILS (TO BE FILLED BY PATIENT/GUARDIAN)

Patient Name:	I.D No/Passport No:
Insurance Company Name:	Date of Birth:
Employer/Scheme Name:	Membership No:
Principal Member Name:	Telephone No:
Relationship to Principal Member:	Email:

Patient/Guardian Signature.. Date..

TREATMENT DETAILS (TO BE FILLED BY THE ATTENDING DOCTOR)

Complaints and date of onset ....
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Physical examination and findings ....
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Laboratory & radiology investigations and findings (attach copies) ....
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Diagnosis...
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Management/Doctor's prescriptions (and estimated costs in case of pre-authorization) ....
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Doctor's Name... Specialty...

Signature and Stamp..

Doctor's Phone Number...

For any question call M-TIBA 0800721253 / 0709071000 ***or email*** *care@mtiba.co.ke*

__NOTE:__ This claim form is to supplement the M-TIBA e- claim and should ideally be completed by the medical personnel attending to patient, scanned, and attached to the M-TIBA e-claim submitted via the portal. For pre-authorizations, kindly always email a copy of this form to care@mtiba.co.ke and call 0800721253 immediately. The physical claim form does not have to be sent to CarePay (nor underwriter) but needs to be kept by the Service Provider for a minimum of 12 months from the treatment date.

2023– Subject to updates notified by CarePay to Service Provider in writing. Updates will take effect 48 hours after the notification was sent.