SWIFT+HMO

Claims Form

Health Care Provider:		Provider ID:	
Name of Enrollee:	Enrollee ID:	No. of Patient Panel:	Sex (please circle):
			Male / Female
Date of Service:	Date of Admission:	Date of Discharge:	Diagnosis:

Details of Treatment				Total Cost (N):
Accommodation N:		for	Days	
Feeding N:		for	Days	
Drugs / Infusion:	Dosage:	Duration:	Cost:	
Procedure and Outcome (Please Specify):				
Investigation and Result (Please Specify):				
			Total (N):	