DOMINION
INSURANCE

REIMBURSEMENT MEDICAL CLAIM FORM
PUBLIC SERVICE COMMISSION GROUP MEDICAL SCHEME
P O Box 2211 Government Building Suva

Insured Name:	
Postal Address:	
Email Address:	
Phone Contact:	EDP/Employee No:
Name of Patient:	
Relationship to the Insured:	
Name of Physician:	
Date Treated:	
Diagnosis:	

COST INCURRED	**CURRENCY (FJD)**
Overseas Claim	
Doctors Fee	
Pharmacy Bill	
X Ray and Lab Charges	
Specialist Fees	
Dental	
Optical	
Maternity	
TOTAL AMOUNT PAID ($)	

IMPORTANT CHECKLIST

(i)	Are All Original Receipts Attached	Yes	No
(ii)	X Ray & Lab Charged - Please Attach Referral Letter from your Doctor	Yes	No
(iii)	Special Referral - Please Attach Referral Letter from your Doctor	Yes	No
(iv)	Optical/Dental – Please attach Optician/Dental Report	Yes	No

BANK ACCOUNT DETAIL
ALL CLAIMS PAYMENT WILL BE CREDITED DIRECTLY TO YOUR BANK ACCOUNT

BANK NAME (*eg: ANZ, WBC, BSP, HFC, BRED BANK AND BANK OF BARODA)*	
BANK ACCOUNT HOLDER'S NAME	
BANK ACCOUNT NUMBER	

SIGNED…… **DATE**…….