ALIG

AUDITING FORM
(RC CLAIMS)

Rec Date: ...../...../200...

Patient Name :	Policyholder:
Policy No. & Plan :	Join Date:
Cons. Date: Broker:	Expiry Date:
Claim Date:	Excel No:
Outpatient Claim ☐ Inpatient Claim ☐	
Invoice Amount (LBP): (as per claim currency) in $:	Others:

☐ Approved ☐ Partially Declined ☐ Totally Declined

Assesment

Medical Audit Signature _____ Date _____

Date	Service/FOB	Claimed Amount	Beneficiary Share	Approved Amount	Declined Reason(s)

	Medex Auditor	Medex Processor	Alig Auditor	Approved
Signature				
Date				