Allianz SNA

# AUDITING FORM
(RC CLAIMS)

Rec Date------/---------/200--

| | | |
|---|---|---|
| Patient Name | | Policyholder |
| Policy N* & Plan | | Join Date |
| Cons. Date | Broker | Expiry Date |
| Claim Date | | Claim N* |
| Outpatient Claim ☐ | Inpatient Claim ☐ | |
| Invoice Amount<br>(per claim currency) | In $ | Others |

☐ Approved ☐ Partially Declined ☐ Totally Declined

SNA REMARKS

Assesment

Medical Audit Signature ____________ Date ____________

| Date | Service / FOB | Claimed amount | Beneficiary share | Approved Amount | Declined Reason(s) |
|---|---|---|---|---|---|
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| Total | | | | | |

| | Medex Auditor | Medex Processor | SNA Auditor | SNA Approval |
|---|---|---|---|---|
| Signature | | | | |
| Date | | | | |