



## REIMBURSEMENT CLAIMS AUDITING FORMS

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

Patient Name		Policyholder	
Policy N* & Plan		Join Date	
Cons. Date	Broker	Expiry Date	
Claim Date		Excel N*	
Outpatient Claim <input type="checkbox"/>	Inpatient Claim <input type="checkbox"/>		
Invoice Amount (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)
<b>Total</b>					

	Medex Auditor	Medex Processor	UCA Auditor	Approved
Signature				
Date				