RECOMMENDATION FORM FOR TICKET REIMBURSEMENT

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Allied Insurance Company

Details of the insured

Name:
Address:
Duration of treatment:
Diagnosis:
Final / Provisional:
Age: Sex: Hospital no: IP / OP: Ward / Bed no:

Assessment of present condition (positive Clinical findings):

Intervention(s) indicated but not available in the Maldives:

Comments by recommending doctor:

Declaration: I hereby DECLARE the forgoing particulars and statements are true and correct to the best of my knowledge. I am fully aware that this document is for the purpose of Allied Insurance Company and the Insurance Company may refer to me for further information to substantiate this recommendation and I agree to provide such information.

Doctor's Name and Signature:	Date:

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