



**DOMINION**  
INSURANCE

**REIMBURSEMENT MEDICAL CLAIM FORM**

*Public Service Commission [PSC]*

- 1. Insured Member : ..... EDP No: .....
- 2. Phone Contact No: .....
- 3. Name of Patient : ..... Relationship:.....
- 4. Name of Physician : ..... Date Treated: .....
- 5. Diagnosis : .....

**6. Cost Incurred:**

- Overseas Claims : .....
- Doctors Fees : .....
- Pharmacy Bills : .....
- X-Ray and Lab Charges : .....
- Specialist Fees : .....
- Dental : .....
- Optical : .....
- Maternity : .....
- TOTAL AMOUNT PAID : \$.....**

**7. Important:**

- i) Are all Original Receipts Attached Yes No
- ii) X- Ray & Lab Charges – Please attach referral letter from your Doctor Yes No
- iii) Specialist Referral – Please attach referral letter from your Doctor Yes No
- iv) Optical/Dental– Please attach Opticians Report Yes No

Insured Members Signature : ..... Date : .....

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