



SECTION - 1 THIS SECTION WILL BE FILLED AND SIGNED BY THE INSURED			
REQUEST FORM FOR CLAIM	INSURED	DOCUMENTS	INVOICE AMOUNT
	NAME / SURNAME ;	1-
	BIRTH DATE ;	2-
	SEX;.....	3-
	CARD NO.....	4-
	GROUP NAME	5-
<p>I accept that I release that commitment of DEMIR HAYAT SIGORTA A.Ş in this respect and the company is authorized to request my health information from all hospitals and persons by me for the claim which is stated in attached documents is TL, accordance with the terms and limits of my health insurance policy.</p>			
<p>The Insured / The Policy Holder :</p>			
NAME / SURNAME ;		DATE ; /	
PHONE :		SIGNATURE ;	



SECTION - 2 THIS SECTION WILL BE FILLED AND SIGNED BY THE DOCTOR	
REQUEST FORM FOR CLAIM	1- PATIENT COMPLAINT / STORY ;
	2- DATE OF FIRST SEEN OF COMPLAINTS ;/...../.....
	3- FINDINGS OF PHYSICAL EXAMINATION :
	4- SPECIFY THE TREATMENTS AND INVESTIGATIONS HAVE BEEN APPLIED BEFORE, THE RESULTS OF THESE AND NAME OF THE HOSPITAL AND THE DOCTOR, BECAUSE OF THESE COMPLAINTS.

	5- VITAL SIGNS ; TA : PULSE : TEMPERATURE : DSS :
	6- PATIENT'S HISTORY ;
	7- PRE-DIAGNOSIS AND/OR DIAGNOSIS :
	8- DIAGNOSTIC TESTS REQUESTED ;
	9- PLANNED TREATMENT ;
DOCTOR'S	
NAME / SURNAME ;	SIGNATURE AND STAMP
BRANCH ;	
DATE ; / /	