APPLICATION FORM FOR REIMBURSEMENT CLAIM

(For Members claiming for Reimbursement)

AlKoot INSURANCE & REINSURANCE
الكوت للتأمين و إعادة التأمين

PATIENT DETAILS

Patient Name:

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

Gender: ☐ Male ☐ Female

Email ID:

Contact No.:

Al Koot Enrolment ID:

Policy No.:

Group / Company Name:

MEDICAL DETAILS

Pre-Approval No.:

Treatment Outside Area of Cover: ☐ Yes ☐ No

Country Name:

Reason for patient being abroad:

Chief Complaints:	Duration of ailment: ☐☐ ☐☐ ☐☐☐☐	Date of first consultation: ☐☐ ☐☐ ☐☐☐☐
Diagnosis:		
Benefit Type: ☐ OP ☐ IP ☐ Day Care ☐ Maternity ☐ Dental ☐ Optical	Date of Treatment (if OP) ☐☐ ☐☐ ☐☐☐☐	Date of Admission (if IP) ☐☐ ☐☐ ☐☐☐☐ Date of Discharge ☐☐ ☐☐ ☐☐☐☐
Treatment Advised:		

CLAIM DETAILS

Amount Claimed:

Please ensure that the amount claimed here is supported by original invoices and prescription

BANK DETAILS

Bank Name:

Bank Branch

Account Number:

Account Holder Name:

IBAN Number:

PROVIDER DETAILS

Provider Name:

Provider Location

Provider Code:

Email ID:

Contact No.:

Name of Treating Doctor:

License No with Seal / Stamp.:

I hereby declare that the information furnished in this Claim Form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim under this claim shall be forfeited.

Date:

Signature of Patient

Place: