Insured by



Gulf Electronic Management Systems Co. W.L.L. genns



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Member's and Patient details: Member's / Patient's Name: Policy No: Patient File No:	Member's and Patient details: Member's A patient's Name: Membership No: Policy No: Class: Patient File No: Address / Tel: 2. To be completed by attending Physician: (please tick □ Inpatient □ Outpatient \ Emergency Case? Yes □ NO□ BP: Pulse: Chief Complaint & Main Symptoms Temp:
Member's and Patient details: Member's / Patient's Name: Policy No: Patient File No:	Membership No: Group Name: Class: Address / Tel: please tick □ Inpatient □ Outpatient \ Emergency C Temp: Duration of illness:
Member's / Patient's Name: Policy No: Patient File No:	Membership No: Group Name: Class: Address / Tel: please tick □ Inpatient □ Outpatient \ Emergency C
Policy No: Patient File No:	Group Name: Class: Address / Tel: please tick Inpatient Outpatient Emergency C
Policy No: Patient File No:	Class: Address / Tel: please tick Inpatient Outpatient Emergency C
Patient File No:	please tick Inpatient Outpatient Emergency C Temp: Duration of illness:
	please tick Inpatient Outpatient Emergency C Temp: Duration of illness:
2. To be completed by attending Physician: (temp:
BP: Pulse:	part and Company and the transfer of the trans
Significant Signs	The best and the first of the same of the same to the
Other Conditions	er mede og over elmelten gen på ble bydovin en en en en med i mer merkenskapperen en en en
Diagnosis	
Principal Code: 2 nd Code:	ode: 3 rd Code: 4 th Code:
3. Please tick (X) where appropriate:	
□ Congenital	TA
☐ Check Up ☐ Psychiatric ☐ I	☐ Infertility ☐ Pregnancy / Indicate LMP:

Tooth No.	Description of treatment	6	
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		A THE	
Please tick the	tooth treated in the diagram		rovida Nam
5. Medical Plan		Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider claim	losed to consider claim
Consultati	tion	Physiotherapy	Cost
			(App. C.), (App. B.)
Pharmacy	y	. Laboratory/Radiology/Other	her Cost
TOTAL CHA	ARGES		
	ian I Desparad i mempedi I se	age Physician: (phase Not October	be be emphated by after
	Section of the rest	5.45 gg.	
6. Patient's Decla	6. Patient's Declaration and Consent	7. Medical Practitioner Declaration	S Minighed 19.43
I confi rm I am the jeff patient under 16 year declare that all the part knowledge true and cothe medical practitione treatment details and and GEMS. I agree the validity of the original.	I confi rm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim benefit and declare that all the particulars given below are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to tazur and GEMS. I agree that a copy of this consent shall have the validity of the original.	I declare that I am the p practitioner and that the part the best of my knowledge t	nt's medical s given are to nd correct.
Signature:	Date:	Signature/Seal:	Date:



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