OMAN
INTERNATIONAL
HOSPITAL
MANAGED BY IDEALMED GHS
مستشفى عُمان الدولي

Al Afia Healthcare Development & Investment Company S.A.O.C
Muscat
CR No: 1281919
Phone: 24903500
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Website: www.omaninternationalhospital.com

INVOICE NO. I OIHOP2022/73298
2022-10-31 - Copy

CIGNA International Corporation

Patient No. 9004703
Name HAYAM YOUNIS MOHAMED AL MUAINI
Policy No. 850515344
Doctor Dr. SeyedehZahra Ghiasi

CR NO.: Consumidor Final

DESCRIPTION	UNIT	GROSS	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
V.OP001040718 - Outpatient	2022/10/31 18:19 - 2022/10/31 22:21				EPISODE **E.001126070**
CONSULTATIONS		**10.000**			
General Practitioner Consultation					
2022-10-31 9 Dr. Sara Ghashghaei	1.00	10.000	0.000	0.000	10.000

GROSS TOTAL	DISCOUNT	PATIENT SHARE	INSURANCE PAYABLE
10.000	0.000	0.000	10.000

Patient Share: 0.000 None
CIGNA International Corporation Total: 10.000 Ten Rial Omani

E & O.E

Cigna®

This form, duly completed and signed, should be returned, along with a detailed invoice to the following:
billing e-mail: **bills@cigna.com**
Or billing address: **P.O. Box 19612 • Greenock PA15 9DB • Scotland**

Provider claim form for direct payment of outpatient medical services

CLAIM ONLY VALID WITH PATIENT SIGNATURE.

Patient information (on patient's Cigna membership card)

CIGNA ID (OR CIGNA PERSONAL REFERENCE NO.) 850515344

NAME - FIRST NAME HAYAM

DATE OF BIRTH (D/M/Y) 24/5/1975

Provider information

NAME OF HOSPITAL/CLINIC

NAME OF DOCTOR/SPECIALIST

PROVIDER ADDRESS

CITY/COUNTRY /

Services rendered (please also attach the invoice(s) and/or the prescription for medication when applicable)

DIAGNOSIS OR NATURE OF ILLNESS K/C of IDA (on iron injection), abd pain dizziness, tiredness, hairloss, palpitation, pale, lappetite

	CURRENCY	TOTAL
AMOUNT OF EXPENSES		
AMOUNT PAID BY PATIENT*		
BALANCE DUE BY CIGNA		

* TO CALCULATE THE PATINET PORTION PLEASE REFER TO THE OUTPATIENT COVERAGE ON THE FRONT OR BACK OF THE CIGNA CARDS

I hereby certify that I or (a) Member(s) of my staff have/has rendered the services as described in attached invoice(s). I also confirm that, to the best of my knowledge, and as I have verified the patient's membership card, the patient treated is indeed the person named on this form.

DATE 31/10/2022

PROVIDER'S SIGNATURE

PROVIDER'S STAMP AND NAME

Dr. Seyedeh Zahra Ghiasi
General Practitioner
MOH License No. 20591
Oman International Hospital

Patient's authorisation

1. I hereby certify that I understand that this claim form will allow Cigna to settle (part of) the claim(s) related to my treatment directly with the health care provider. I hereby also authorise the above mentioned health care provider to provide Cigna's Medical Consultant with all information that may be relevant or necessary for the correct assessment of this claim. I hereby certify that I will not lay any claim to Cigna against monies receivable by the provider of medical services.
2. I hereby agree to return the patient portion to Cigna in case there is a difference between the amount paid by Cigna to the provider and the covered expenses according to my plan benefits.
3. I hereby certify that I received the services as descibed in the attached invoice(s).
4. In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the data protection).

DATE 31/10/2022

PATIENT'S SIGNATURE