

**Claim Reimbursement Form**

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| 1.DETAILS OF INSURED | | |
| a) Patient Name: | b) Membership No.: | Class: |
| c) Policy No.: | d) Insured Name: | |
| e) Employee Code: | f) Mobile No.: | |

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| 2.DETAILS OF CLAIMS | |
| Type Of Visit: Inpatient Outpatient Maternity Dental Optical Emergency Others  ccv  cv  cv  cv  cv  cv  ccv | |
| a) Provider Name: | b) Date Of Treatment: |
| c) Treatment Taken: Saudi Arabia Outside of Saudi Arabia  ccv  ccv | |
| d) Diagnosis: | |
| e) Present Illness History: | |

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| 3.DETAILS OF BILLS ENCLOSED | | | |
| Sr. No. | Invoice No. | Date | Amount In SR |
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|  |  |  |  |
| Grand Total | | |  |

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| 4.CLAIM DOCUMENT CHECKLIST |
| Claim form duly signed  ccv  Original Invoices  kkdjccv  Payment Receipt  ccv  Supporting Investigations Reports (Lab, X-ray  ccv  Etc.)  Copy of the preapproval if treatment outside  ccv  geographical area  Summary of invoices if number of invoices  ccv  more than space provided in column no .3 |

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| 5. DETAILS OF CLAIMANT ACCOUNT INFORMATION | |
| a) Iqama / ID No. | b) IBAN No.: |
| c) Bank Name: | d) Account No.: |

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| 6.DECLARATION BY CLAIMANT | |
| I hereby declare that the information furnished in the claim form is true and 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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. | |
| Signature of Claimant & Date: | Stamp & Signature of Insurance Manager |