

Please give the following information correctly and completely to enable the Company to process your claim promptly.

Claimants Name:		Claimants Date of Birth	Age / gender			
		Claimants Civil ID				
Employee Name:		Employee No.				
Relationship	Spouse / Son / Daughter	Telephone No.			Email ID:	
Date of Admission / Service:			Date of Discharge:			
Provider Name :			Claimed Amount :			

To Be Filled By Treating Consultant / Service Provider

Diagnosis: _____

Details of Disease/Illness contracted or injury suffered: _____

Acute () Chronic () Congenital () Others ()

Date of Injury sustained or Disease/Illness first detected _____

Dental Services

Service	Amount	Service	Amount
Extraction		Scaling	
Filling		Cleaning	
RCT		Crown	
X-Ray		Bridge	
Gum Treatment		Whitening	
Others(Provide Details)			

Maternity Services (MANDATORY FOR MATERNITY CASES)

Infertility treatment taken for the present pregnancy: Yes () No ()	
Date for L.M.P	Date for E.D.D.
Maternity Status: Gravida () Para () Abort () Live ()	

Name of the Doctor: _____

Sign & Stamp of Doctor: _____ Telephone No.: _____

I/We hereby warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make any false or untrue statement, suppression or concealment, my/our right to claim reimbursement of the said expenses shall be absolutely forfeited. I/We further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance. I/We hereby authorize WAPMED to check all the medical records related to treatment from the Doctor/Hospital.

Date: _____

Claimant's Signature: _____

Hospital Stamp: _____