

Dental Claim Form

Please give the following information correctly and completely to enable the company to process your claim promptly:

TO BE COMPLETED BY MEMBER / CLAIMANT

1. Name of the Company / main Member: _____ Policy Number: _____ (In whose name policy is issued, Name of the Company in case of Group policy)	
2. Detail of the Insured Person / Member (In respect of whom claim is made) :	
Patient's Name:	Membership No. (UHID No.)
Gander: Male <input type="checkbox"/> Female <input type="checkbox"/>	Employee Number (Policy Group) :
Date of Birth (dd/mm/yyyy)	Other Medical Insurance Coverage- Yes / No
Telephone Number	(If Yes attach details)
Relationship with the Insured :	
Patient Address :	
3. Medical Provider Name / Address : _____	
4. Date Admission / Service : _____ Date of Discharge : _____	
5. Claimed Amount : _____ Currency : _____	

To Be Completed By Treating Doctor

Diagnosis : _____			
Date of Injury Sustained or Diseases/Illness first detected : _____			
Type of Treatment	Amount	Type of Treatment	Amount
Extraction		Filing	
Neurectomy		Gum Treatment	
X-ray		R.C.T.	
Cleaning		Scaling	
Bridge		Orthodontics	
Dentures		Crown	
Restoration		Prophylaxis	
Total Amount			
Other Investigation Done : _____			

Name of the Doctor : _____

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

Member's / Hospital's Declaration :

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 hereby authorize Al Muthanna Takaful Insurance Co. / Wapmed or their authorized representatives to check all the medical records related to treatment from the doctor / hospital.

Member's Signature : _____ Hospital's Signature : _____