شركة المثنى للتأمين التكافلي (ش.م.ك.م)
Al-Muthanna Takaful Insurance Co. (K.S.C.C)

AL-MUTHANNA

Treatment Type
OP ☐ IP ☐ M ☐ O ☐

In / Out – Patient 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 ☐ Female ☐		Employee Number (Policy Group) :	
Date of Birth (dd/mm/yyyy)		Other Medical Insurance Coverage- Yes / No (If Yes attach details)	
Telephone Number			
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 : ____

Details of Diseases/Illness contracted or injury suffered : ____

Acute ( ) Chronic ( ) Congenital ( ) Other ( )

Date of Injury Sustained or Diseases/Illness first detected : _____________________________________

Infertility treatment taken for the present pregnancy (For Maternity Claims) Yes ( ) No ( )

Obstetric Status : _________________________ LMP : ____________________ EDD : ________________________

Treatment Given : ____

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 : ___________________________