

**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: \_\_\_\_\_