MEDICAL CLAIM FORM

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

Claimants Name:		Date of Birth		Age / gender	
		Civil ID			
Employee Name:		**File No.**			
Relationship	Spouse / Son / Daughter	Telephone No.		Email ID:	@nbk.com

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:**___________________