ENAYA INSURANCE

شركة عناية للتامين (ش.م.ك.م.)
ENAYA INSURANCE COMPANY (S.A.K.) CLOSED

Treatment Type

OP☐ IP☐ M☐ O☐

برج العربية الطابق 15، شارع أحمد الجابر، الشرق ص ب 5859 – الصفاة 13059 الكويت ، سجل تجاري 118271 تلفون ١٨٢٢٢٠٠ ٩٦٥+ فاكس ٧٣ / ٢٢٢٦٧٤٧١ ٩٦٥+
Al Arabia Tower 15th Floor, Ahmed Al Jaber Street, Sharq - P.O. Box 5859, Safat 13059 Kuwait - CR No 118271 Tel +965 1822200 Fax +965 22267471 / 73
insure@enaya.com - www.enaya.com

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- Details of the Insured Person/Member (In respect of whom claim is made) :

Patient's Name :		**Membership No. (UHID No.)**	
Gender : Male ☐ Female ☐ **Civil ID Number**		**Employee Number** **(allotted by the employer) :**	
Date of Birth (dd/mm/yy)		**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 of Admission / Service : ..... **Date of Discharge :** .....

5- Claimed Amount : ..... **Currency :** .....

To Be Completed By Treating Doctor

6- Diagnosis : .....

7- Details of Diseases/Illness contracted or injury suffered : .....

Acute ( ) **Chronic ( )** **Congenital ( )** **Others ( )** **Dental ( )**

8- Date of Injury Sustained or Diseases/Illness first detected : .....

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

10- Obstetric Status : ..... **LMP :** ..... **EDD :** .....

11- Treatment Given : .....

12- Name of the Doctor : .....

13- 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 Enaya 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 :** .....

Date : ..... **Stamp of Hospital :** .....