

برج العربية الطابق 15، شارع أحمد الجابر، الشرق ص ب 5859 - الصفاة 13059 الكويت . سجل تجاري 118271 تلفون ١٨٢٢٢٠٠ +٩٦٥ فاكس ٢٢٢٦٧٤٧١ / ٧٣ +٩٦٥
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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 <input type="checkbox"/> Female <input type="checkbox"/>		Employee Number (allotted by the employer) :	
Civil ID Number		Other Medical Insurance Coverage – Yes / No (If Yes attach details)	
Date of Birth (dd/mm/yy)			
Telephone Number			
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 :

For any queries kindly contact :  Ahmad Al-Jaber Street, Sharq, PO Box:26739, Safat-13128,

Kuwait - PH No.(965) 22466247/8, Fax:22466234, email: info@wapmed.net, visit: www.wapmed.net

For Complaints / Emergency: 24 x 7 Mobile Number: 66341658