Insurance Copy

01401

شركة رتاج للتأمين التكافلي (ش.م.ك.م)

Ritaj Takaful Insurance Company (K.S.C.C)

Treatment Type

OP ☐ IP ☐ M ☐ O ☐

Sharq, Ahmad Al-Jaber Street, P.O.Box: 53056 Al-Nuzha, 73061 Kuwait, Ph No. (965) 830033, Fax: 2438981, E-mail: info@ritajins.com

IN/OUT-PATIENT CLAIM FORM

Please fill in the following form 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 the 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 for)

Patient's Name		Membership No. (UHID No.)	
Gender : Male ☐ Female ☐		Employee Number (Policy Group):	
Date of Birth (D/M/Y)		Other Medical Insurance Coverage- Yes / No (If Yes attach details)	
Telephone Number			
Relationship with the Insured :			
Patient Address :			

10. Medical Provider Name / Address : ____________

11. Date of Admission / Service : ____________ Date of Discharge : ____________

12. Claimed Amount : ____________ Currency : ____________

TO BE COMPLETED BY TREATING DOCTOR

13. Diagnosis : ____________

14. Details of Disease/Illness contracted or injury suffered : ____________

Acute ( ) Chronic ( ) Congenital ( ) Others ( )

15. Date of Injury sustained or Disease/Illness first detected : ____________

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

17. Investigations done : ____________

18. Treatment Given : ____________

19. Name of the Doctor : ____________

20. Sign & Seal of Doctor : ____________ Tel 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 absolutelly forfeited. I/We hereby authorise Ritaj Takaful Insurance Co./WAPMED TPA services or their authorized representatives to check all the medical records related to treatment from the Doctor/Hospital.

Member's Signature : ____________ Hospital's Signature : ____________

Date : ____________ Seal of Hospital : ____________

For any queries kindly contact: WAPMED TPA Services Co. Ahmad Al-Jaber Street, Sharq, P.O.Box: 26739, Safat-13128, Kuwait
Ph No. (965) 2466247/8, Fax: 2466234, email: info@wapmed.net, visit: www.wapmed.net

CERTIFIED QUALITY MANAGEMENT SYSTEM