

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 (Policy Group) :	
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 ()

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 Takaful International For Takaful 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 :