

**For any queries contact:**

U.A.E. - Phone: +971-4-4458215, Fax: +971-4-4370531, E-mail : info@wapmed.net

Kuwait - Phone: +965-22466247, Fax: +965-22466243, Website: www.wapmed.net



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

1. Healthcare Provider :	2. Patient's Name :
3. Date of Service : <u>    </u> / <u>    </u> / <u>20</u> <u>    </u> <u>    </u>	4. Patient's Tel :
5. DOB: <u>    </u> / <u>    </u> / <u>20</u> <u>    </u> <u>    </u>	6. Gender : <input type="checkbox"/> F <input type="checkbox"/> M
7. Member No. :	8. Patient's Employer : (Mandatory)
9. Patient's File No. :	10. Insurance Co. : (Mandatory)

**TO BE COMPLETED BY TREATING DOCTOR**

11. Diagnosis :
12. Details of disease / Illness contracted or injury suffered :
13. Date of Onset of Present Symptom : <u>    </u> / <u>    </u> / <u>20</u> <u>    </u> <u>    </u>
14. <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Congenital <input type="checkbox"/> Others (Please Specify)

**In case of Surgery, Physiotherapy, Hospitalization, MRI/CT Scan, Echocardiogram, Treadmill Test, Doppler or any other Daycare Procedure, Please fill the following details & get it pre-approved :**

15. Likely date of Admission / Service : _____	16. Approx. Length of Stay : _____ days
17. Estimated Expenses : _____ (Total)	18. Class of Accommodation : _____
Room Rent : _____	Dr Charges : _____ Package (If Applicable) : _____
Pharmacy & consumables : _____	Investigation/s : _____ Others : _____

**MATERNITY SERVICES**

19. Has the Patient taken Infertility Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes. Attach details :</i>
20. L.M.P : <u>    </u> / <u>    </u> / <u>20</u> <u>    </u> <u>    </u>
21. E.D.D. : <u>    </u> / <u>    </u> / <u>20</u> <u>    </u> <u>    </u>
22. <input type="checkbox"/> Gravida <input type="checkbox"/> Para <input type="checkbox"/> Abort <input type="checkbox"/> Live

**23. DENTAL SERVICES (Please mention Tooth No. & Tooth Surface)**

SERVICE	NO. OF TOOTH / AMOUNT	SERVICE	NO. OF TOOTH / AMOUNT

**DETAILS AS PRESCRIBED / ADVISED BY TREATING DOCTOR (Per Prescription max. 30 days medicine)**

24. <input type="checkbox"/> PHARMACY :	Cost	25. <input type="checkbox"/> LABORATORY / RADIOLOGY :	Cost

<b>26. HOSPITAL / CONSULTANT/CLINIC :</b>	<b>27. PHARMACY :</b>	<b>28. DIAGNOSTIC CENTRE :</b>
Consultant Name : _____	Pharmacy Name : _____	Centre's Name : _____
Tel/Fax (Important) : _____	Tel/Fax (Important): _____	Tel/Fax (Important): _____
Signature & Stamp : _____	Signature & Stamp: _____	Signature & Stamp: _____

*I hereby authorize the Medical Service Provider/Insurer/Employer or any other organization to provide required information about me and/or any of my family member/s to WAPMED, including but not limited to copies of my/their medical records related to any sickness, accident, treatment, examination, advice or hospitalization. I also understand that the medical expenses coverage is governed by the terms and conditions of the policy and I hereby undertake to bear cost for deductibles and/or utilization in excess and/or charges for uncovered services. Medical management is the sole responsibility of doctor and the patient. A photocopy of this authorization shall be deemed as the original.*

29. \_\_\_\_\_  
Patient's Signature (Parent if minor)

    /    /20