I/O-1252

Insurance Copy

شركـة وربـة للتأميـن ش.م.ك
WARBA INSURANCE COMPANY K.S.C

Ahmad Al-Jaber Street, Sharq, PO Box: 24282, Safat-13103, Kuwait Ph No.- (965) 808181, Fax: 2466131

INPATIENT/OUT-PATIENT CLAIM FORM

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

1. **Name of the Company/Main Member** ______________________________
   (In whose name policy is issued, Name of the Company in case of Group policy)
2. **Details of the Insured Member** (In respect of whom claim is made)

Patient's Name and Address:		Membership No. (UHID No.)	
		Relationship with the insured	
Policy No.:		Date of Birth	
Other Insurance Coverage- Yes/No (If yes attach details)		Gender (Male/Female)	
Employee Number (Group Policy):		Telephone Number	

10. **Name & Address of the Hospital** : ______________________________
11. **Date of Admission / Service** : ____________ **Date of Discharge:** ____________
12. **Claimed Amount** : ____________ **Currency:** ____________

OP ☐ IP ☐ M ☐

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 & Stamp of Doctor: ____________ Telephone 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 Warba / 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- WAPMED TPA Ahmad Al-Jaber Street, Sharq, PO Box: 26739, Safat-13128, Kuwait Ph No.- (965) 2466247/8, Fax: 2466234, email- info@wapmed.net, visit: www.wapmed.net