Reimbursement Claim Form

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

TO BE COMPLETED BY THE INSURED MEMBER

1. Name of the Insured Main Member:

2. Patient's Name (for whom the claim is enclosed):	**Membership No.** (UHID No.):
	Relationship with main Insured:
	Date of Birth:
	Gender (Male/Female):
	Policy No.:

3. Name of the Hospital/Clinic:

4. Date of Admission/Service:	**Date of Discharge:**
5. Amount Claimed:	**Currency:**

TO BE COMPLETED BY TREATING DOCTOR FOR INPATIENT/OUTPATIENT CLAIM.

6. Diagnosis:

7. Details of Diseases/Illness contracted or injury suffered:

☐ **Acute** ☐ **Chronic** ☐ **Congenital** ☐ **Others**

8. Date if injury sustained or Disease/Illness first detected:

9.Details of Pregnancy/Maternity Claims:

Date of L.M.P / / / **Date of E.D.D / / /**

Maternity Status ☐ **Gravida** ☐ **Para** ☐ **Abort** ☐ **Live**

10. Investigations Done:

11. Treatment Given:

12. Name of the Doctor:

13.Sign and Stamp of Doctor:	**Telephone No.**

For any queries contact WAPMED TPA Services Co. Ahmad Al- Jaber Street, Sharq. P.O.Box 26739, Safat -13128, Kuwait
Tel No. (965) 2246 6247, Fax No. (965) 2246 6234, Email : claimsinfo@wapmed.net , Visit: www.wapmed.net

WARBA INSURANCE
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TO BE COMPLETED BY TREATING DOCTOR FOR DENTAL CLAIM

14. Date of injury sustained or Disease/ Illness detected (dd/mm/yyyy) :

Type Of Treatment	Amount	Type Of Treatment	Amount
Extraction		Filling	
Neurectomy		Gum treatment	
X-ray		R.C.T	
Cleaning		Scaling	
Bridge		Orthodontics	
Dentures		Crown	
Restoration		Prophylaxis	
Others		TOTAL CLAIMED AMOUNT	

15. Other Investigations Done

16. Name of the Doctor:

17.Sign and Stamp of Doctor: **Telephone No.**

MEMBER'S DECLARATION

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent,in whole or part, I am committing a criminal offence and that will invalidate the claim and make me liable for prosecution. For this medical claim, I authorize any medical practioner, specialist, consultant, therapist or other relevant establishment who have attended me/the patient in the past or at present, to give any details that may be asked by Warba Insurance Co. / WAPMED. I confirm and agree that any personal information collected or held by Warba Insurance Co. / WAPMED, whether given on this form or collected in any other way, maybe used by Warba Insurance Co. / WAPMED to disclose or to transfer to any organization for the purpose of i) assessing this claim and giving on-going insurance cover,customer service and the processing of furture claims ii) processing and making payments.

Member's Signature

Date (dd/mm/yyyy)

CHECKLIST

Send your claim to WARBA Insurance Co/WAPMED TPA Service Co with the following documents.

- The original itemised bill
- The original payment receipt
- The fully completed and signed medical claim form (clearly mentioning the full name of the Payee/Staff in whose name the cheque will be issued).
- Copy of the prescription
- Copy of all lab & medical reports
- Discharge summary for Inpatient cases.
- Copy of the Health Card

Completed claim form along with the relevant supporting bills and prescriptions must be submitted to WARBA/WapMed TPA Services Co, no later than 60 days from treatment date. Failure to comply with the sixty days period shall invalidate the claim and no benefits shall be payable