APPLICATION FORM FOR REIMBURSEMENT CLAIM

(For Members claiming for Reimbursement)

AlKoot INSURANCE & REINSURANCE الكوت للتأمين و إعادة التأمين

PATIENT DETAILS

Patient Name: ZAHRA ALI SAMO

Date of Birth: 25 01 2019

Gender: ☐ Male ☒ Female

Email ID: [illegible]

Contact No.: 55403117

Al Koot ID: 11-

Policy No.:

Group / Company Name: QATARGAS

MEDICAL DETAILS

Country Name:

Date of Treatment:

Diagnosis:

Duration of ailment:

Date of first consultation: ☐☐ ☐☐ ☐☐☐☐

Presenting Complaints:

PRE-MATURE BABY IN ICU SINCE BIRTH

Benefit Type: ☐ OP ☐ IP ☐ Day Care ☐ Maternity ☐ Dental ☐ Optical

Admission Date: ☐☐ ☐☐ ☐☐☐☐ Discharge Date (for IP): ☐☐ ☐☐ ☐☐☐☐

Treatment Details:

CLAIM DETAILS

Amount Claimed:

Please ensure that the amount claimed here is supported by original invoices and prescription

BANK DETAILS

Bank Name: Branch Name:

Account Holder Name: Account No.:

IBAN No.:

PROVIDER DETAILS

Provider Name:

Email ID:

Name of Treating Doctor:

Dr. Shawgi Mohammed
Specialist, OB-GYN/AKH - HMC
0..2806

Location: ALKHOR HAMAD

Contact No.: 50455143

License No. with Seal and signature:

Declaration:

I hereby authorize any Medical providers to give access and provide AlKoot Insurance or any of AlKoot affiliates with all my or my family health records including copies with no exception regardless of the previous Payer/insurer. I agree that a copy of this consent shall have the validity of original. Also, I declare that the information furnished in this Claim Form including the bank details is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim under this claim shall be forfeited.

Patient's Signature with Date: