التاريخ:

* Valid CID
* Patient Insurance Card
* I-BAN No.
* Company ID
* Original Invoice No
* Reception …………………….
* Insurance Officer …………

Medical Group

Health Insurance

Medical Claim Form

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **جهة العمل** |  | | | | | | | | | | | | | | | | | | **Company Name** | |
| **رقم التوظيف** |  | | | | | | | | | | | | | | | | | | **Employment No.** | |
| **اسم العامل** |  | | | | | | | | | | | | | | | | | | **Employee Name** | |
| **اسم متلقي العلاج** |  | | | | | | | | | | | | | | | | | | **Patient Name** | |
| **صلة القرابة** | الزوجة | | الزوج | | | | الابن | | | | | | الابنة | | | | نفسه | | **Relationship** | |
| Wife | | Husband | | | | Son | | | | | | Daughter | | | | Self | |
| **رقم الهاتف النقال** |  | | | | | | | | | | | | | | | | | | **Mobile No.** | |
| **البريد الالكتروني** |  | | | | | | | | | | | | | | | | | | **E Mail** | |
| **الرقم المدني للعامل** |  | | | | | | | | | | | | | | | | | | **Employee CID** | |
| **الرقم المدني للمريض** |  | | | | | | | | | | | | | | | | | | **Patient CID** | |
| **رقم حساب البنك/IBAN** |  | | | | | | | | | | | | | | | | | | **Bank Account No/IBAN** | |
| **نوع العلاج** | أسنان | حمل وولادة | | | | دخول مستشفى | | أمراض مزمنة | | | | معدات | | نظارة | | | | عيادة خارجية | **Type of Treatment** | |
| Dental | Maternity | | | | Inpatient | | Chronic | | | | Equipment | | Optics | | | | Outpatient |
| **تاريخ العلاج** |  | | | | | | | | | | | | | | | | | | **Date of Treatment** | |
| **رقم الفاتورة** |  | | | | | | | | | | | | | | | | | | **Invoice No.** | |
| **قيمة المطالبة** |  | | | | | | | | | | | | | | | | | | **Claim Amount** | |
| **سبب الدفع** | ليست ضمن الشبكة | | | | غير مغطاة تأمينا | | | | | | عدم حمل البطاقة | | | | | تعدي السقف الأعلى | | | **Reason for payment** | |
| Non-Network | | | | Not Covered | | | | | | Card N/A | | | | | Over limit | | |
| **خاص بفريق التأمين الصحي** | | | | | | | | | | **For HIT Use** | | | | | | | | | |
| **رقم المطالبة** | **/ /2020-2021** | | | | | | | | | | | | | | | | | | **Claim No.** | |
| **القيمة الاجمالية للمطالبة** |  | | | | | | | | | | | | | | | | | | **Total Claim Amount** | |
| **المبلغ المغطى تأمينا** |  | | | | | | | | | | | | | | | | | | **Covered By Insurance** | |
| **مبالغ غير مغطاة** |  | | | | | | | | | | | | | | | | | | **Amount not Insured** | |
| **مبلغ التعويض** |  | | | | | | | | | | | | | | | | | | **Approved Amount** | |
| **أسباب رفض المطالبة** |  | | | | | | | | | | | | | | | | | | **Remarks** | |
| **المستشار الطبي** |  | | | | | | | | | | | | | | | | | | **HIT Medical Advisor** | |
| **رئيس فريق التأمين الصحي** |  | | | | | | | | | | | | | | | | | | **Team Leader HIT** | |
| ا**لمرفقات** | تقرير طبي | | | تحاليل طبية | | | | | وصفة طبية | | | | | | أشعة قبل وبعد (للأسنان) | | | |  | |
|  | Med. Report | | | Lab Tests | | | | | Prescription | | | | | | X-rays Before & After | | | | **Attachments** | |