

e-Reference No.

Reimbursement Claim Form

Provider:	Medical Record No.:	Date: dd / mm / yyyy
Patient Name:	E-mail:	Age/DOB:
MEM: Mandatory	Qatari/Civil ID:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Marital Status:	Policy Holder:	Policy No.:
Payment to: <input type="checkbox"/> Member <input type="checkbox"/> Employer	Payment Method: <input type="checkbox"/> Cheque <input type="checkbox"/> Bank Transfer	
In case bank transfer is selected,	Bank Name:	Account No.:
Swift Code/IBAN:	Bank Address:	
<input type="checkbox"/> New Visit <input type="checkbox"/> Follow-up	<input type="checkbox"/> OP <input type="checkbox"/> ER	<input type="checkbox"/> Day care <input type="checkbox"/> IP
In case of in-patient admission,	Admission Date: dd / mm / yyyy	Discharge Date: dd / mm / yyyy

To be filled by Medical Practitioner

Present Illness Details:	Past Medical History:
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Acute Chronic Accident Hereditary/Congenital Work Related Pregnancy **LMP:** dd / mm / yyyy

Diagnosis: Mandatory	Duration of Illness: Mandatory
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Lab / Radiology:

Code	Procedure	Cost (Currency)
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Medical Practitioner Declaration	Patient Declaration
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<p>I hereby certify that all medical information mentioned is to the best of my knowledge true and the medical services shown on this form are medically indicated & necessary for the management of the patient medical condition.</p> <p>Treating Physician:</p> <p>Specialty:</p> <p>Contact No.:</p> <p>Signature or Stamp:</p>	<p>I hereby certify that the entire particulars given above are true. I hereby authorize QLM Insurance Company to discuss, access and obtain a copy of my health records (or any of my dependents' records) that may be requested by them or their appointed representative. I also agree that a copy of this declaration stands valid as original.</p> <p>Patient/Guardian</p> <p>Signature: Date: dd / mm / yyyy</p> <p>Mobile No.:</p>
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