AL KHAZNA INSURANCE COMPANY

Paid Up Capital : AED 380,000,000 Medical Hot Line: 050-7906628

MEDICAL CLAIM FORM

MEDICAL PROVIDER ADMINISTRATOR'S SECTION

Group's Name:_____ Provider's Name:_____

Patient's Name:_____ Doctor's Name:_____

Policy No:_____ Date:_____

DOB:_____. Insured Tel No.:_____ Admission Date / Time:_____

DOCTOR'S SECTION

Medical History:_____

_____

Clinical Symptoms & Onset Date:_____

_____

Diagnosis or R/O:_____

_____

Treatment:_____

Classification of Medical Case: **Chronic** ☐ **Maternity** ☐ **Dental** ☐ **Optical** ☐

Out Patient Investigations / Treatment required:

Laboratory	Radiology	Others	Medicines / IVFluids

Doctor's signature & Stamp:

INSURANCE DEPARTMENT'S SECTION (FOR PRE-AUTHORIZATION'S REQUEST)

Cost Break up requiring pre -approval:

Items	Gross Rates	Approved Rates (Filled by AKIC)	Net Rates (Filled by AKIC)
Room & Board			
Surgeon's Fee			
Anesthetist's Fees			
Operating Theatre			
Consultations Fees			
Laboratory			
Radiology			
Medicines			
Others			
Total			

Provider's Stamp

PATIENT'S SECTION

I hereby authorize Al Khazna Insurance Company's authorized representatives to obtain any requisite medical details from my current and previous medical records / doctors. Also, I guarantee to pay any expenses not covered by insurance plan or in excess of the limits provided under the plan or any deductible or co-insurance determined by this plan.

Date: _____. Insured member's signature (Parent/Guardian if Minor):_____

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