SAICO Claim Form

Please use this form for any services received on or after 01 January 2011 from network providers in **Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates.**

SAICO

MEDICAL EXPENSES CLAIM FORM

A. EMPLOYEE'S SECTION

Member No.: _____ Employee No.: _____ Birth date: _____

Patient Name: _____ State Nature of Illness: _____

Country of Treatment: _____ Date of Treatment: _____

Employee Name: _____ Email address: _____

Bank Account No: _____ Bank Name: _____

Mailing Address: _____

(Settlement cheque can be deposited if you have an account with a bank in Abu Dhabi or will be mailed to this address)

Authorization: I the undersigned, hereby certify that all answers and all documents submitted with this Claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me and/or any of my family members to provide SAICO with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

BREAKDOWN OF EXPENSES (compulsory)	**CURRENCY**:	
Dr's FEES (consultation)		
MEDICINES		
OTHERS (lab, X-Rays, etc)		
TOTAL AMOUNT CLAIMED:		

Member's signature: _____ Date: _____ Contact No.: _____

B. PHYSICIAN'S SECTION

Patient name (CAPITALS): _____ Age: _____

Diagnosis (CAPITALS): _____ ICD: _____

Type of treatment: [ ] Illness Date first seen _____

[ ] Accident Work Related YES / NO Date: _____ Time: _____

Cause: _____ Place: _____

[ ] Pregnancy Date of LMP: _____ Expected delivery date: _____

[ ] Hospitalization Date admitted:_____ Date discharged: _____

PHYSICIAN'S DECLARATION: I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.

Physician's Stamp: _____ Signature: _____ Date: _____

C. ATTACHMENT'S REQUIRED

1. Invoices with proof of payment.
2. Doctor's prescription for medicines, lab tests, X-ray's etc.
3. Pharmacy invoice clearly showing name of medicine, quantity purchased and price of each medicine.
4. Copy of patient's SAICO membership card.

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