REIMBURSEMENT FORM

Claim Form - Part A
For Health Insurance Policies
TO BE FILLED IN BY THE INSURED
The issue of this form is not to be taken as an admission of liability

A. DETAILS OF PRIMARY INSURED:

a) Policy No:
b) Sl. No/Certificate No:
c) Company TPA ID No:
d) Customer ID:
e) Name:
f) Address:
City:
State:
Pin Code:
Phone No:
Email ID:

B. DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes / No

b) Date of Commencement of First Insurance without break:

c) If yes, Company Name:

d) Policy No:

e) Sum Insured (OMR):

f) Have you been hospitalized in the last four years since Inception of the Contract?

Yes / No

i) Date:

j) Diagnosis:

k) Previously covered by any other Mediclaim / Health Insurance: Yes / No

l) If Yes, Company Name:

C. DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name:

b) Gender: Male / Female / Other

c) Age: - - Years - - Months

d) Date of Birth:

e) Relationship with the Primary Insured: Self / Spouse / Child / Father / Mother / Other

f) Occupation: Service / Self-Employed / Homemaker / Retire / Student / Other

g) Address (If different from above):

City:
State:
Pin code:

h) Phone No:

i) Mail ID:

C. Details of Hospitalization:

1. In Patient

A. Name of Hospital / Healthcare center:

B. Room Category:

i. Day care
ii. Private Room
iii. Sharing Room

C. Date of Injury / Illness First Detected / Date of Delivery:

D. Date of Admission & Time:

Date of Discharge & Time

2. Out-Patient:

A. Physical Illness
B. Accident
C. Maternity
D. Preventive
E. Psychiatric Illness
F. Physiotherapy
G. Work Related
H. Acute
I. Chronic
J. Suspected
K. Other

3. Dental
4. Optical
5. Alternative Treatment

3. If injury give cause :

A. Self-Inflected B. Road Traffic Accident C. Substance abuse / Alcohol consumption

4. If Medicolegal: YES / NO

6. Reported to ROP: YES / NO

7. MLC Report & FIR Attached: YES / NO

E. DETAILS OF CLAIM:

a. Details of Treatment Expenses claimed:

1. In-Patient Claim:

   a. Pre-Hospitalisation Expenses: OMR
   b. Pos-Hospitalisation Expenses: OMR
   c. Hospitalisation Expenses: OMR
   d. Health Investigation & Checkup Cost: OMR
   e. Ambulance Charges: OMR
   f. Others: OMR
   g. Total Charges

2. Out-Patient Claim:
    a. Consultation
    b. Laboratory / Radiology / Other
    c. Pharmacy
    d. Physiotherapy
    e. Total Charges

3. Others:
a. Air Ambulance: OMR
b. Family Visit of Immediate Family Member: OMR
c. Repatriation: OMR
d. Hospital Cash Benefit (If Government Hospital): OMR
e. Parents / Companion Accommodation: OMR

F. Claim Documents Submitted - Check List:

**Member should enclose the Resident Card Copy & Medical Card Copy with all reimbursement claim.

1. Claim Form Duly signed
2. Copy of the Claim Intimation, if any
3. Hospital Main Bill
4. Hospital Break-up Bill
5. Hospital Bill Payment Receipt
6. Hospital Discharge Summary
7. Pharmacy Bill
8. Operation Theatre Notes
9. ECG
10. Doctor’s request for investigation
11. Investigation Reports (Including CT/ MRI / USG / HPE)
12. Doctor’s Prescriptions
13. Others

G. Details of Bills Enclosed:

SI No	Bill No	Date			Issued By	Towards	Amount (OMR)
		DD	MM	YYYY			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

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C.R: 1190750, P.O. BOX 207, Postal Code 134, Bareeq Al Shatti, Sultanate of Oman, Tel: +968 22303000 , 80078264 , 24699781 , Fax: +968 24699511
Email: info@takafuloman.om Website: www.takafuloman.om

H. DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:
   1. Account Name:
   2. A/C Number:
   3. Bank Name
   4. Swift Code:

I. DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this Claim form 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 with respect to questions asked in relation to this Claim, my right to Claim reimbursement shall be forfeited. I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any Hospital / Medical Practitioner who has attended to the person against whom this Claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this Claim & that I will not be making any supplementary Claim except the pre/post-hospitalization Claim, if any.

Date:

Place:

Signature of the Insured

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Claim Form - Part B
For Health Insurance Policies
TO BE FILLED IN BY THE HOSPITAL / HEALTH CARE CENTER

Details of Hospital:

a) Name of Hospital
b) Hospital ID
c) Type of Hospital – Network / Non-Network
d) Name of Treating Doctor
e) Qualification
f) Registration No / License No
g) Phone No

DETAILS OF INSURED PERSON HOSPITALIZED:

a. Name:

b. Gender: Male / Female / Other

c. Age: - - Years - - Months

d. Date of Birth:

e. Relationship with the Primary Insured: Self / Spouse / Child / Father / Mother / Other

f. Occupation: Service / Self-Employed / Homemaker / Retire / Student / Other

g. Address (If different from above):
City:
State:
Pin code:

h. Phone No:

i. Mail ID:

Detail of Ailment Diagnosed (Primary):

	ICD 10 Codes	Description		ICD 10 PCS	Description
Primary Diagnosis			Procedure 1		
Additional Diagnosis:			Procedure 2		
Co-morbidities			Procedure 3		
Co-morbidities			Details of Procedure		

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1 Pre-authorisation Obtained – Yes / No

2 Pre-authorisation No –

3 If authorization by network hospital no obtained, give reason:

4. Hospitalization due to injury: Yes / No

If Yes, Give cause

A. Self-Inflected B. Road Traffic Accident C. Substance abuse / Alcohol consumption

If injury due to Substance abuse/alcohol consumption, Test conducted to establish this: Yes / NO

5. If Medicolegal: YES / NO

1. Reported to ROP: YES / NO

2. MLC Report & FIR Attached: YES / NO

3. FIR No :

if not reported to police give reason:

CLAIM DOCUMENTS -CHECK LIST

a. Claim form duly signed
b. Original Pre-Authorization request
c. Copy of Pre-Authorization letter
d. Copy of photo ID card of patient verified by hospital
e. Hospital discharge summary
f. Operation theatre notes
g. Hospital main bill
h. Hospital break up bill
i. Ingestion reports
j. CT/MR/USG/HPE investigation report
k. Doctor's reference slip for investigation
l. ECG
m. Pharmacy bills
n. MLC report & Police FIR
o. Original death summary from hospital where applicable
p. Any other, please specify

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)
We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.
I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to Takaful Oman Insurance SAOG for the purpose of determining insurance benefits.

Date:
Place:

Signature and Seal of the Hospital Authority

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