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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