

APPLICATION FORM FOR REIMBURSEMENT CLAIM

(For Members claiming for Reimbursement)

PATIENT DETAILS

Patient Name:

Date of Birth:

Gender: Male Female

Email ID:

Contact No.:

Al Koot Enrolment ID:

Policy No.:

Group / Company Name:

MEDICAL DETAILS

Pre-Approval No.:

Treatment Outside Area of Cover: Yes No

Country Name:

Reason for patient being abroad:

Chief Complaints:

Duration of ailment:

Date of first consultation:

Diagnosis:

Benefit Type:

OP IP Day Care

Date of Treatment (if OP)

Date of Admission (if IP)

Maternity Dental Optical

Date of Discharge

Treatment Advised:

CLAIM DETAILS

Amount Claimed:

Please ensure that the amount claimed here is supported by original invoices and prescription

BANK DETAILS

Bank Name:

Bank Branch

Account Number:

Account Holder Name:

IBAN Number:

PROVIDER DETAILS

Provider Name:

Provider Location

Email ID:

Name of Treating Doctor:

Provider Code:

Contact No.:

License No with Seal / Stamp.:

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, my right to claim under this claim shall be forfeited.

Signature of Patient

Date:

Place: