DENTAL REIMBURSEMENT CLAIM FORM

AlKoot INSURANCE & REINSURANCE الكوت للتأمين و إعادة التأمين

PATIENT DETAILS

Patient Name: Al Koot ID No.:

Employee No.: Qatar ID:

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Gender: ☐ Male ☐ Female

Email ID: Contact No.:

Company Name: Policy No:

TREATMENT DETAILS

Date of Treatment: _____ Date of first Consultation: _____

Chief Complaints: _____

Duration of Ailment: _____ Any relevant past history: _____

Diagnosis: _____

Treatment details: _____

Tooth Number(s): _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____

CLAIM DETAILS

Amount Claimed:

Please ensure that the amount claimed here is supported by original invoices, proof of payment and prescription

PROVIDER DETAILS

Provider Name:

Name of Treating Doctor: Provider Location:

Country Name: License No:

BANK DETAILS

To facilitate speedy settlement, please ensure that your latest bank details are registered with AlKoot Insurance & Reinsurance. To register or update your bank details please login to your AlKoot Global Care Mobile app, AlKoot Member Portal or submit copy of your bank details on bank letterhead to: customercare@alkoot-medical.com. **Please note that only Principle's (main policy holder) bank details are accepted**

DENTAL HEALTH COMPONENT (DHC) **(To be filled for Orthodontic Treatment)**

Dento Class: ☐ Class I ☐ Class II D ☐ Class III D

Skeletal Class: ☐ Class I ☐ Class II ☐ Class III

DENTAL REIMBURSEMENT CLAIM FORM

AlKoot INSURANCE & REINSURANCE الكوت للتأمين و إعادة التأمين

(Continuation for Orthodontic Treatment)

1. OVERJET: _____ mm

2. CONTACT POINT DISPL.: _____ mm

3. CROSS BITE: _____ mm (Anterior)
_____ mm (Posterior)
_____ mm (Betn. RCP & ICP)

4. OPEN BITE: _____ mm (Anterior)
_____ mm (Posterior)
_____ mm (Lateral)

5. REVERSE OVERJET: _____ mm

Speech / Masticatory Difficulty: ☐ Yes ☐ No

6. OVER BITE: _____ (Deep)
_____ (Complete)
_____ (Incomplete)
_____ (None)

Palatal Trauma: ☐ Yes ☐ No:

Gingival Trauma: ☐ Yes ☐ No:

7. HYPODONTIA:

Quadrant 1 Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Quadrant 2 Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Quadrant 3 Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Quadrant 4 Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

8. OTHER CONDITIONS:

Impended Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Impacted Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Submerged Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Supernumerary Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Retained Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

Ectopic Teeth#: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

9. CRANIO FACIAL ANOMALY: _____

AESTHETIC COMPONENT

1	2	3	4	5	6	7	8	9	10

(tick the right score**)**

DECLARATION:

I hereby authorize any Medical providers to give access and provide AlKoot Insurance or any of AlKoot affiliates with all my or my family health records including copies with no exception regardless of the previous Payer/insurer. I agree that a copy of this consent shall have the validity of original. Also, I declare that the information furnished in this Claim Form including the bank details 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.

Patient's Signature with Date:

Signature of the treating doctor with stamp: **Date:**