

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 ID:

Policy No.:

Group / Company Name:

MEDICAL DETAILS

Country Name:

Presenting Complaints:

Date of Treatment:

Diagnosis:

Duration of ailment:

Date of first consultation:

Benefit Type: OP IP Day Care Maternity Dental Optical

Admission Date:

Discharge Date (for IP):

Treatment Details:

CLAIM DETAILS

Amount Claimed:

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

BANK DETAILS

Bank Name:

Branch Name:

Account Holder Name:

Account No.:

IBAN No.:

PROVIDER DETAILS

Provider Name:

Location:

Email ID:

Contact No.:

Name of Treating Doctor:

License No. with Seal and signature:

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:

Al Koot Insurance & Reinsurance Company (Licensed by the Qatar Central Bank) P.O.Box 24563, Doha-Qatar.

For any further clarifications or complaints procedure guide, please use the below contact details

Call: (+974) 800 2000; **Email:** customercare@alkoot-medical.com; **Website:** www.alkoot.com.qa