REIMBURSEMENT DENTAL CLAIM FORM

GlobeMed Qatar

Provider Name | Patient File # | Adherent name

Insurance Co | Mobile # | Individual Number

Date of Visit | CID # | Policy Holder

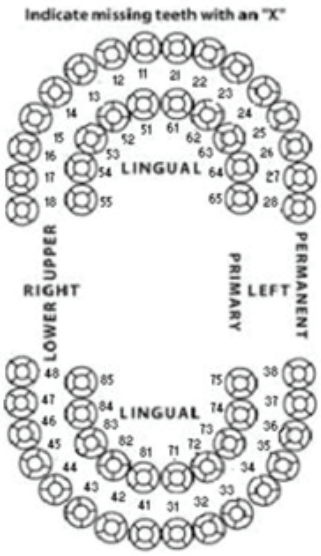
(to be completed by the dentist)
DURATION OF DISEASE

CHIEF COMPLAINT & MAIN SYMPTOMS

PLEASE CHECK WHERE APPROPRIATE

◯ RTA ◯ Cleaning ◯ Work Related Accident ◯ Sports Related ◯ Check-Up ◯ Congenital\Developmental ◯ Orthodontics\Esthetics

Type of Treatment	Tooth No./Letter	Cost
Extraction		
Neurectomy		
X-ray		
Cleaning		
Bridge		
Dentures		
Filling		
Gum Treatment		
R.C.T		
Scaling		
Orthodontics		
Crowns		
Prophylaxis		
Others		
TOTAL CLAIMED AMOUNT		



I the undersigned, hereby declare the following: I give full authorization to the Insurance Company and/or employer adhering to GlobeMed and its representatives to inquire about my past and actual state of health. I also authorize them to inform my attending physician, within their capacities, of the information available at their end about my state of health. Hence, I request from the healthcare provider to reveal and provide the Insurance Company and/or employer and GlobeMed and its representatives, with all available information concerning my person that are known to them or that are held in their files and medical records and photocopies of it.

NAME **SIGNATURE**

I hereby certify that ALL information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

Dr.

DENTIST SIGNATURE & STAMP

DATE ____ / ____ / ____

DOCUMENTS NEEDED FOR REIMBURSEMENT CLAIMS

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DOCUMENTS NEEDED FOR DOCTOR VISIT, AMBULATORY TESTS AND HOSPITALIZATION REIMBURSEMENT CLAIMS

1. Detailed Medical Report signed and stamped by the treating physician (Diagnosis, complaints, past medical history, duration of illness and other conditions).
2. Detailed original invoice i.e. cost per item.
3. Results for all tests done e.g. labs, radiology, cytopathology... etc.
4. Discharge summary for in-patient cases.

المستندات المطلوبة لإعادة تسديد زيارة الطبيب والفحوصات الخارجية وحالات الاستشفاء داخل المستشفى

1. تقرير طبي مفصل موقع ومختوم من قبل الطبيب المعالج يشرح وضع المريض الصحي (التشخيص، شكوى المريض، بداية ظهور الاعراض او الحالة المرضية، التاريخ المرضي السابق و اي حالات اخرى)
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.
3. نتائج التحاليل المخبرية والاشعة وتحاليل الانسجة (الباثلوجيا الخلوية) ...الخ.
4. التقرير النهائي عند خروج المريض من المستشفى (فقط في حالة الاقامة داخل المستشفى للحالات المرضية او الجراحية)

DOCUMENTS NEEDED FOR PRESCRIPTION MEDICINE REIMBURSEMENT CLAIMS

1. Original prescription or a stamped copy of the prescription in case the prescribed medicines are antibiotics or steroids.
2. Detailed original invoice i.e. cost per item.

المستندات المطلوبة لإعادة تسديد الأدوية موضوع وصفة طبية

1. الوصفة الأصلية أو صورة مختومة بخاتم الصيدلية في حالة وصفات المضادات الحيوية ومركبات الكورتيزول.
2. فاتورة اصلية مفصلة محدد فيها سعر كل دواء.

DOCUMENTS NEEDED FOR DENTAL TREATMENT REIMBURSEMENT CLAIMS

1. Panoramic X-ray
2. Detailed original invoice i.e. cost per item.

المستندات المطلوبة لإعادة تسديد علاج الاسنان

1. الأشعة السنية (Panoramic).
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.

A copy of the insurance card and the Civil ID should be enclosed.

يجب ان يرفق مع كل طلب صورة عن بطاقة التأمين والبطاقة المدنية.

PAYMENT DETAILS

GlobeMed Qatar

Have you personally had to pay costs for the treatment that you are claiming for? ◯ Yes ◯ No

If yes, and you are personally seeking reimbursement, please tell us how you wish to be reimbursed (Please tick one):

1- ◯ **Bank transfer.** Please fill in this information for bank transfer payments: (Please note that this is the quickest and safest method of payment)

Name of account holder

Name of your bank | Account number

Address for your bank

IBAN number

Routing code / swift code / sort code | Currency of bank account

2- ◯ **Foreign draft.** Please tell us what currency

MEMBER'S DECLARATION

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by Insurance Company/ GlobeMed. I confirm and agree that any personal information collected or held by Insurance Company/GlobeMed, whether given on this form or collected in any other way, may be used by Insurance Company/GlobeMed or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving on-going insurance cover, customer service and the processing of future claims, ii) processing and making payments, iii) providing marketing communications in respect of Insurance Company/GlobeMed, its related products and services and those of its associated companies.

Member's Signature

Date (dd/mm/yy)