Insured by

tazur

TPA

gems

Gulf Electronic Management Systems Co. W.L.L

Claim Form

Provider Name:	Date: / /	Time:

Member's and Patient details:

Member's / Patient's Name:	Membership No:
	Group Name:
Policy No:	Class:
Patient File No:	Address / Tel:

2. To be completed by attending Physician: (please tick ☐ Inpatient ☐ Outpatient \ Emergency Case ? Yes ☐ NO ☐

BP: _____ Pulse: _____ Temp: _____ Duration of illness: _____

Chief Complaint & Main Symptoms _____

_____

_____

Significant Signs _____

_____

Other Conditions _____

Diagnosis _____

Principal Code: _____ 2nd Code: _____ 3rd Code: _____ 4th Code: _____

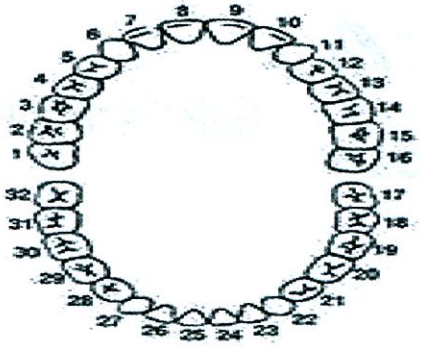
3. ***Please tick (X) where appropriate:***

☐ **Chronic** ☐ **Congenital** ☐ **RTA** ☐ **Work Related** ☐ **Vaccination**

☐ **Check Up** ☐ **Psychiatric** ☐ **Infertility** ☐ **Pregnancy / Indicate LMP:**

4. Dental Care (To be completed by the Dentist)

Tooth No.	Description of treatment



Please tick the tooth treated in the diagram

5. Medical Plan Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider claim

☐ Consultation	Cost	☐ Physiotherapy	Cost
☐ Pharmacy	Cost	☐ Laboratory/Radiology/Other	Cost
TOTAL CHARGES			

6. Patient's Declaration and Consent

I confi rm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim benefi t and declare that all the particulars given below are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to t'azur and GEMS. I agree that a copy of this consent shall have the validity of the original.

Signature: ..... Date: .....

7. Medical Practitioner Declaration

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Signature/Seal: ..... Date: .....

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