Al Sagr National Insurance Co.

NEXtCARE®
*Your Health Managed with Care*

# REIMBURSEMENT CLAIM FORM

*Please Complete Clearly (All Fields Mandatory)* Form No. _____

## PATIENT & FACILITY INFORMATION:

| | | | |
|---|---|---|---|
| Healthcare Facility : | Patient Name : | | |
| Date of Healthcare Visit : ____/___ / _____ *dd mm yyyy* | Patient Tel. : | DOB ____/_____/_____ *dd mm yyyy* | SEX : F ☐ M ☐ |
| Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ | | Patient's Employer : | |

## HISTORY OF PRESENT ILLNESS & PAST MEDICAL HISTORY (To *be completed by physician)*

Reason for consultation ( Chief Complaint)

History of present illness & Date of symptom onset : _____/ _____/ _____ *dd mm yyyy*

Past medical or surgical history (s) :_____/ _____/ _____ *dd mm yyyy*

Current Medications? Yes ☐ No ☐ *if yes, indicate the diagnosis and duration of treatment :*

## REVIEW OF SYSTEMS - DIAGNOSIS / DIFFERENTIAL DIAGNOSIS (To *be completed by physician)*

Clinical findings : Vital Signs: B/P:_____ T:_____ HR:_____RR:_____

Cause: ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work Related ☐ Other

| Diagnosis / Etiology : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected *Indicate Diagnosis / Differential diagnosis* | *DIAGNOSIS CODE* |
|---|---|
| 1. | |
| 2. | |
| 3. | |

Is diagnosis related to another assessment? Yes ☐ No ☐ *If Yes, specify ( i.e. Retinopathy related disorder)*

## MANAGEMENT PLAN *Itemized Original Invoices & Applicable Prescriptions/ Reports/ Results must be enclosed to consider the claim.*

| | | | |
|---|---|---|---|
| ☐ Consultation | *Cost* | ☐ Physiotherapy | *Cost* |
| ☐ Pharmacy | Cost | ☐ Laboratory | *Cost* |
| ☐ Radiology | Cost | ☐ Other Services | *Cost* |
| *TOTAL CHARGES* | | | |

Hospital Admission ☐ Y ☐ N Hospital Name _____ No. of Days ____Procedure _____Cost _____

**Discharge Summary, Itemized, Invoices, Reports & Receipts Attached?*

Treating Physician Name: _____
Tel / Fax # _____
Signature & Stamp :_____

I, the undersigned, confirm the information I have given herein is true & correct. I consent to the release of any medical information regarding my medical condition and history to Al Sagr National Insurance Company (ASNIC) for the purposes of insurance benefit determination and eligible reimbursement claim settlement. I also extend this release to include ASNIC's representative TPA as noted on my ASNIC insurance card, if applicable. I agree that a copy of this consent shall have the validity of original.

Patient Tel / Fax_____

Patient E-Mail _____

Claims should be submitted within 90 days from the date of service