

Healthcare Claim Form

Please complete this form using block CAPITALS LETTERS and by ticking the relevant circles. You must complete sections 1, 2, 3 and 4. Your medical practitioner must complete sections 5 to 8. Both you and your medical practitioner must sign and date this form, and it must be accompanied by original receipted invoices and prescriptions or it may not be processed. If you have any questions regarding this form or any other aspects of your coverage, please telephone AXA at +966 1 478 0282 and ask for the Healthcare Department.

Please note that prior approval is required for any expenses likely to exceed SR 750.

1 Patient's details

Employer	Name	Policy #	/	/	/
Patient	Name	Member #	/	/	/
Address	P.O. Box	City	Post code		
	Phone	Mobile	Fax		
Email					
Date of birth	(day/month/year)	/	/	When did the patient first joined the scheme?	/

2 To be completed by Patient (or member if Patient is under 16 years of age)

2.1 **Payment Information:** Address to which payment should be sent (if different from above)

2.2 Payments will be made in Saudi Riyals unless pre-agreed. **I request a settlement by check in the order of:**

2.3 If you are submitting a claim for treatment received outside your area of coverage, please answer the following questions:

a) Country where treatment took place

b) The reason for the patient being abroad

c) Dates of departure and return to Saudi Arabia

2.4 Is the treatment accident-related? Yes No

2.5 Is it covered under another insurance policy? Yes No

If you answered 'Yes' to this question, please give the name of the insurance company involved.

3 Breakdown of expenses

In which currency was the treatment originally billed?	
Doctor visit	
Drugs	
Others (Lab, X-Rays, etc.)	
Total	

4 Patient's declaration and consent

I confirm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim benefit and declare that the particulars given above 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 AXA Insurance. I agree that a copy of this consent shall have the validity of the original.

Signature: _____ Date (dd/mm/yyyy): _____

5 Medical section (to be fully completed by patient's medical practitioner - all boxes must be completed in block capitals please)

5.1 **Diagnosis** - Medical condition requiring treatment:

5.2 Please give the date your patient **first** became aware of any signs or symptoms of the conditions being claimed for: (day, month & year)

5.3 Please give the date on which your patient **first** presented to any doctor for this condition:

5.4 **Symptoms / History** - please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates:

5.5 **Investigations / Treatment** - please give full details of any current investigations and/or treatment:

5.6 **Drugs** - drugs/other items prescribed:

5.7 **Follow up** - please give details of any further treatment planned:

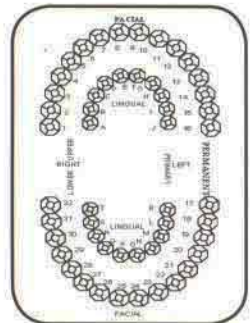
Name of medical practitioner: Practice stamp:

Name of patient receiving treatment:

6 Dental Care (to be completed by the dentist)

Tooth No.	Description of treatment

Please tick the tooth treated in the diagram.



7 Hospital or clinic information (to be completed by medical practitioner)

Hospital or Clinic name and address:

Admission/Treatment date: / /

Surgery date (if any): / /

Discharge date (if any): / /

8 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 Date (dd/mm/yyyy)

The claim form must be submitted within 60 days of the start of the treatment along with all original receipts/invoices - as per Policy membership Agreement. Claims will not be considered if not submitted within 2 months of treatment being received. The issue of this form does not imply any liability on the part of AXA Insurance.

Please note: You are advised to keep a record of all information supplied in connection with this Application, including any letters you send us in connection with it. If you would like a copy of this application, please let us know within 3 months.

Send this claim form together with supporting material to:
Healthcare Department, AXA Insurance E.C., P.O. Box 21044, Riyadh 11475, Saudi Arabia
 Tel: +966 1 478 0282 Fax: +966 1 477 3097