

e-Reference No.

Reimbursement Claim Form

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|---|---|--|
| Provider: | Medical Record No.: | Date: dd / mm / yyyy |
| Patient Name: | Age/DOB: | |
| MEM: Mandatory | Omani/Civil ID: | Gender: <input type="checkbox"/> F <input type="checkbox"/> M |
| Marital Status: | Policy Holder: | Policy No.: |
| <input type="checkbox"/> New Visit | <input type="checkbox"/> Follow-up | <input type="checkbox"/> OP |
| | <input type="checkbox"/> ER | <input type="checkbox"/> Day care |
| | | <input type="checkbox"/> IP |
| In case in-patient admission is recommended, | Admission Date: dd / mm / yyyy | Length of Stay: |

To be filled by Medical Practitioner

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|---|--|
| Present Illness Details: | Past Medical History: |
|---|--|

Acute
 Chronic
 Accident
 Hereditary/Congenital
 Work Related
 Pregnancy
 LMP: dd / mm / yyyy

| | |
|-----------------------------|---------------------------------------|
| Diagnosis: Mandatory | Duration of Illness: Mandatory |
|-----------------------------|---------------------------------------|

Lab / Radiology:

| Code | Procedure |
|-------|-----------|
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Medical Practitioner Declaration

Patient Declaration

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| I hereby certify that all medical information mentioned is to the best of my knowledge true and the medical services shown on this form are medically indicated & necessary for the management of the patient medical condition. Treating Physician: Specialty: Contact No.: Signature or Stamp: | I hereby certify that the entire particulars given above are true. I hereby authorize OQIC Insurance Company to discuss, access and obtain a copy of my health records (or any of my dependents' records) that may be requested by them or their appointed representative. I also agree that a copy of this declaration stands valid as original. Patient/Guardian Signature: Date: dd / mm / yyyy Mobile No.: |
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