

## HEALTH INSURANCE CLAIM FORM



(Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers)

Name of the insured: \_\_\_\_\_  
(in whose name policy is issued)

Membership No.: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Details of insured person: \_\_\_\_\_  
(in whose name claim is made)

Relationship to the insured: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nature of illness/disease/injury: \_\_\_\_\_

Name and address of attending medical practitioner: \_\_\_\_\_

Name and address of hospital/nursing home/clinic: \_\_\_\_\_

Date of admission: \_\_\_\_\_

Date of discharge: \_\_\_\_\_

Details of inpatient treatment taken: \_\_\_\_\_

Date of outpatient treatment taken: \_\_\_\_\_

Other insurer's details: \_\_\_\_\_  
(if the treatment is covered under another insurance policy/please provide name of insurance company)

Medical Section (to be fully completed by patient's medical practitioner)

Medical Practitioner's Name: \_\_\_\_\_ Tel.: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_ Medical Practitioner's stamp

Patient's Declaration and Consent

**I confirm I am the patient/patient's parent or guardian (if patient is under 16 years of age) and wish to claim benefits and declare that all 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 case to discuss treatment details and discharge arrangement with and to Neuron. I agree that a copy of this consent shall have the validity of the original.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This claim form should be submitted within 30 days of discharge from the hospital/completion of treatment along with all original receipts/invoices as per the policy membership agreement. Claims will not be considered if not submitted within 3 months of treatment being received. Send this claim form together with supporting material to: Medical Claims Department, Al Ahlia Insurance Co., PO BOX 1463, PC 112, Ruwi, Muscat, Sultanate of Oman, Tel.: 24766800, 24766821, Fax: 24797151, Website: www.alahliaoman.com**