NATIONAL CLAIM & APPROVAL FORM (DENTAL & OPTICAL) Sr. No.

SECTION A: TO BE COMPLETED BY MEMBER

Member Name: _____ **M** ☐ **F** ☐

Policy Number: _____ **ID. Number:** _____

D.O.B _____ **File No.** _____ **Mob. No.** _____ **Date of Visit:** ___ / ___ / ____

SECTION B: TO BE COMPLETED BY DENTIST

1. Chief Complaint & Main Symptoms: .....

2. Duration of illness .....

3. Diagnosis.....

4. Please tick (☑)where appropriate:

☐ **RTA** ☐ **Work Related Accident** ☐ **Sports Related** ☐ **Cleaning**

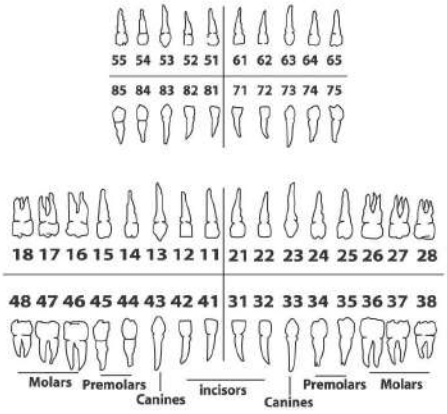
☐ **Orthodontics\Esthetics** ☐ **Congenital/Developmental** ☐ **Check-Up**

5. Anticipated plan of treatment/procedures

.....

.....

Permanent



Service	Cost
Doctors Fee	.....
Medicine	.....
X-Ray	.....
Dental procedures (specify)	.....
	.....

Anticipalted Total Cost _____ **Anticipalted Date of Rx** _____

SECTION C: TO BE COMPLETED BY OPTHALMOLOGIST/OPTICIAN

	RIGHT EYE						LEFT EYE					
	Sphere	Cylinder	Axis	Prism	V/A		Sphere	Cylinder	Axis	Prism	V/A	PD
Distance												
Near												

Right Lens Cost ..... **Left Lens Cost** .....

Frame Cost ..... **Anticipated Total Cost** .....

SECTION D: DECLARATION TO BE SIGNED BY ATTENDING PHYSICIAN AND THE MEMBER OR GUARDIAN

I hereby crtify that ALL information mentioned herein are correct & that the services shown on this form were medically indicated & necessary for the management of this case.

Name of Physician:

Signature:

Stamp& Licence No: _____ *Date:* / /

I, the undersigned, hereby declare that the above mentioned services have been rendered to me in full and confirm that the settlements contained herein are true and that all relevant information has been disclosed.
I hereby authorize my insurer/TPA to review my file if any further information or clarification is required.

The receipt of this claim form/ other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Member Signature _____
(TO BE SIGNED ONLY AFTER COMPLETION OF TREATMENT IN FULL)

Date of completion of treatment: / /

FOR INSURANCE COMPANY USE ONLY:

☐ **Approved** ☐ **Not Approved** **Comments:** .....

Approved No.: ..... **Approved Validity :**..... .....

Insurance Officer: **Signature:** **Date:** / / **CLAIM No.** _____

Hotline and Pre-authorization contact numbers: 80014367, 66004414, Fax - 17911260
For Approvals Email : info@gemstpa.com, helpdeskdoctor@gemstpa.com