



GULF UNION



NATIONAL CLAIM FORM - PRIMARY MEDICAL CARE

Sr. No.

SECTION A: MEMBER DETAILS (TO BE FILLED BY THE INSURED)

Member Name:	Insurance Company/ TPA Name:
Membership /Policy No:	Policy Holder:
Date of Birth: Gender: M <input type="checkbox"/> F <input type="checkbox"/>	CPR/Passport Number:
Single <input type="checkbox"/> Married <input type="checkbox"/>	Member's Phone Number:

SECTION B: MEDICAL SECTION (TO BE FILLED ONLY BY THE TREATING PHYSICIAN)

Please Tick : [] Inpatient : [] Outpatient : [] Emergency Case	Provider Name:
Date of Treatment:	Medical Record No :
Pre Existing Condition: <input type="checkbox"/> RTA <input type="checkbox"/>	Vital Signs:
Chronic Condition: <input type="checkbox"/> Work Related Accident <input type="checkbox"/>	Blood Pressure :
Maternity <input type="checkbox"/> EDD.....	Pulse :
Others (please specify):	Temp :
Main Complaint & Presenting Symptoms:	Duration/History of illness:

Clinical Finding and Final Diagnosis: (use ICD codes as appropriate)

PRE-AUTHORIZATION SECTION (MEDICAL & INVESTIGATION REPORT MUST BE ATTACHED WHERE APPLICABLE)

Plan of Management/ Treatment	Expected Date of Admission:	Anticipated Length of Stay:
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Package Deal Code:	ANTICIPATED COST:
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Member Declaration <i>I the undersigned hereby certify that all statements & information provided concerning identification & the present illness or injury are TRUE. Furthermore, I authorize and request the Hospital to provide my Insurer / TPA with any information they request in connection with any treatment and/or services provided to me and grant them full access to my medical files.</i> <i>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.</i>	Medical Service Provider Declaration <i>I/We hereby certify that ALL information mentioned herein are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.</i>
Signature:	Name of Doctor:
Date:	Signature:
	Stamp & License No. Date:

FOR INSURANCE COMPANY USE ONLY:

Approved	Not Approved	Comments:
Approval No.:	Approved Validity:	
Insurance Officer:	Signature:	Date: / / CLAIM No.