NATIONAL CLAIM FORM - PRIMARY MEDICAL CARE

Sr. No.

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

Member Name:	**Insurance Company/ TPA Name:**
Membership /Policy No:	**Policy Holder:**
Date of Birth: **Gender: M ☐ F ☐**	**CPR/Passport Number:**
Single ☐ **Married ☐**	**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: ☐ RTA ☐ **Chronic Condition: ☐ Work Related Accident ☐** **Maternity ☐ EDD .....** **Others (please specify): .....**	**Vital Signs:** **Blood Pressure :** **Pulse :** **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:**

Package Deal Code :	**ANTICIPATED COST:**

Member Declaration

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.

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.

Signature: .....

Date:.....

Medical Service Provider Declaration

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.

Name of Doctor: .....

Signature: .....

Stamp & Licence No. **Date:.....**

FOR INSURANCE COMPANY USE ONLY:

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

Approval 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

Pre-Authorization Requirements

Pre Authorization is required for Inpatient & Day Case services.Prescribed medication above ONE month.MRI/CT Scan/All profile investigations/Physiotherapy/Any single service above Pre-approval limit mentioned in TOB.

PLEASE NOTE THESE ARE THE COMMON GENERAL EXCLUSIONS AND PRE-AUTHORIZATION REQUIREMENTS.
FOR FURTHER DETAILS PLEASE REFER TO THE TABLE OF BENEFITS OF EACH POLICY, MEMBERSHIP CARD AND THE INSURANCE COMPANY/TPA SERVICE AGREEMENT AND THEIR GUIDELINES.

T'azur General Exclusions

- Pre-Existing conditions (unless specified in TOB)
- Chronic conditions (unless specified in TOB)
- Home visits
- Routine medical examinations or regular checkups (unless specified in TOB)
- Medical certificates and examination for residence, employment or travel
- Provider registration fees and medical report charges
- Vaccinations (unless specified in TOB)
- Circumcision(unless specified in TOB)
- Cosmetic, plastic, reconstructive and restorative treatment.
- Cosmetic products like Shampoos, soaps, hair stimulants, hair removers, moisturizers, creams or similar products.
- Alternative medicines (unless specified in TOB)
- Treatment or tests for AIDS and AIDS/HIV related conditions (unless specified in TOB)
- Any illness caused or resulting from sexually transmitted disease.
- Organ transplant (Unless specified in TOB)
- Organ donor related charges and organ acquisition charges
- Prosthesis (including stents) and medical appliances (unless specified in TOB)
- Obesity related treatment
- Psychiatric treatment (unless specified in TOB)
- Vitamins, minerals and supplements (unless specified in TOB)
- Skin disorders (Warts, Acne ,lipoma, keloid, skin tags, epidermal cyst, uninfected sebaceous cyst, molluscumcontagiosum)
- Maternity (Unless specified in TOB)
- Dental (Unless specified in TOB)
- Optical (Unless specified in TOB)
- Infertility, impotency, sexual dysfunction, contraception and sterilization.
- Congenital and developmental disorder
- Hearing defects
- Professional and hazardous sports related injury.
- Work related injuries
- IVF treatment
- Pregnancy and delivery in women whose contractual status is single.
- Growth hormone treatment
- Hair disorders
- Sleep related breathing disorders (Snoring, sleep apnea, fatigue, work related stress)
- Investigations and treatment not relating to the illness.
- Intentional self inflicted injury.
- Sickness as a result of abuse of some medicines, tranquilizers or from use of alcohol, drugs or similar substances.
- Visiting Doctors and Non contracted Doctors (unless specified in TOB)