QIC

شـــركـــة قطـــر للتـــأميـــن
Qatar Insurance Company

QATAR CARE
Group Health Insurance

MEDICAL CLAIM FORM

To be filled by the Health Provider

- Provider Name: .....
- File Number: .....
- Date: .....
- Clinic: .....
- Patient relationship to the member:

Self ☐ Spouse ☐ Child ☐ Other ☐

QIC Medical ID card Information

Please verify patient's name with his ID or passport.

- Name of Insured: .....
- Medical ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
- Policy Holder: .....
- Policy Number: ☐☐☐☐☐☐☐☐☐☐

Authorization: I declare that the entire particular given above are to the best of my knowledge true and correct, I hereby authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with QIC. I permit that a copy of this authorization shall have the validity of the original.

Patient's Signature: ..... Date: / /

To be filled by Patient's Medical Practitioner

- Present illness details:

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- Date symptoms first appeared: / / Patient age: ..... Sex: Male ☐ Female ☐
- Is the illness is: Pregnancy related? ☐ Congenital? ☐ Work related? ☐ Chronic? ☐
- Past medical history details:

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- Diagnosis, Clinical findings and management:

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- Is inpatient recommended? Yes ☐ No ☐ If yes, why? "Specify the requested line of management"

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Proposed inpatient period: ..... | Proposed date of admission / / | Time: .....

Medical Practitioner Declaration

I certify that the medical services shown on this form were medically indicated & necessary for the treatment of the ailment

Practitioner's Name ..... | Signature: ..... | Tel.: .....

For Provider Accounts Use | Total cost "Gross" ..... Price list ☐ P. Deal Cost ☐

QIC Comments: Approved ☐ Not Approved ☐

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QIC in charge name: ..... | Signature: ..... | Date: / /