

## Inpatient Claim Form Direct Billing - Healthcare Insurance

One Claim Form per person.

Section 3 & 4 to be filled by treating doctor & Section 5 by patient. All other sections to be filled by Administrative Personnel.

Please write in BLOCK LETTERS. In case additional details need to be provided, please photocopy this sheet.

1. Provider Details		Claim Form Number:	
Provider Name		Facility License Code	

  

2. Member/Patient Details	
Card Number	Date of Birth (dd/mm/yyyy)
Patient's Name (as it appears on the card)	
Telephone Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Medical Record Number	
Reason for Visit	<input type="checkbox"/> Emergency <input type="checkbox"/> Road traffic accident <input type="checkbox"/> Work related accident <input type="checkbox"/> New visit <input type="checkbox"/> Follow up <input type="checkbox"/> Referral
Referral source	

  

3. Medical Section	
Chief complaint & duration	
First consultation date for above condition (dd/mm/yyyy)	
Admitting Diagnosis	
ICD Code(s)	
Discharge Diagnosis	
Treatment Details	
CPT Code(s)	
Actual/Expected Date of Admission (dd/mm/yyyy)	Days of stay

  

4. Doctor's Declaration	
I declare that I am the patient's treating doctor and the particulars given are true and correct to the best of my knowledge.	
Doctor's Stamp:	Signature: Date:

  

5. Patient's Declaration	
I confirm that all particulars above are true. I hereby authorize (i) the medical provider and any other entity to provide and discuss health/treatment details with Oman Insurance Company and/or third party administrator (ii) Oman Insurance Company to (a) disclose my personal/claim information for claim processing or as may be required (b) contact me for claim/other products information. I agree that a copy of this consent shall have the validity of original.	
Name:	Signature: Date: