Medical Authorization Centre: 800 6626
General Inquiries: 800 4746

عمـــان للتأميـــن
Oman Insurance

Outpatient 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

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	☐ Male	☐ Female	
Medical Record Number					
Reason for Visit	☐ Emergency	☐ Road traffic accident	☐ Work related accident		
	☐ New visit	☐ Follow up	☐ Referral		
Referral source					

3. Medical Section

Chief complaint & duration				
First consultation date for above condition (dd/mm/yyyy)				
Initial Diagnosis				
Please tick the appropriate box	☐ Maternity	☐ Acute	☐ Chronic	☐ Congenital
If maternity related, please indicate LMP				
How long patient is aware of the complaint?				
Final Diagnosis				
ICD Code(s)				
Treatment Details				
CPT Code(s)				
Preauthorisation				

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:	