رؤية جديدة للتأمين التعاوني
redefining cooperative insurance

Healthcare
Claim Form

Please complete this form using block CAPITAL LETTERS and by ticking the relevant circles. You must complete sections 1, 2, 3 and 4. Your medical practitioner must complete sections 5 to 6. Both you and your medical practitioner must sign and date this form, and it must be accompanied by original receipted invoices and prescriptions or it may not be processed. If you have any questions regarding this form or any other aspects of your coverage, please telephone AXA at: +966 1 478 0282 and ask for the Healthcare department.

Please note that prior approval is required for any expenses likely to exceed SAR 1000

1. Patient's details

Employer:	Name:		Policy#
Patient:	Name:		Member#
Address:	P.O.Box:	City:	Post Code:
Contact:	Phone:	Fax:	Mobile:
Email:		Date of Birth: Day:	Month: Year:
When did the patient first joined the scheme:			

2. To be completed by patient (or member if patient is under 16 years of age)

2.1 **Payment information:** Address to which payment should be sent (If different from above)

2.2 Payments will be made in Saudi Riyals unless pre-agreed. **I request a settlement by check in the order of:**

3. Breakdown of expenses

In which currency was the treatment originally billed?	
Doctor visit	
Drugs	
Others (Lab, X-Rays, etc.)	
Total	

4. Patient's declaration and consent

I confirm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim benefit and declare that the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Cooperative Insurance. I agree that a copy of this consent shall have the validity of the original

Signature Date(dd/mm/yyyy)

X_____ X_____

5. Medical Section (to be filled by patient's medical practitioner - all boxes must be completed in block capitals please)

5.1 **Diagnosis** - medical condition requiring treatment:

5.2 **Drugs** - drugs/other items prescribed:

Day: Month: Year:

5.3 **Follow up** - please give details of any further treatment planned:

Name of the medical practitioner:

Practice stamp

Name of the patient receiving treatment:

6. Medical Practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Signature X_____ Date(dd/mm/yyyy)X_____

The claim form must be submitted within 60 days of the start of the treatment along with all original receipts/invoices - as per policy membership Agreement. Claims will not be considered if not submitted within 2 months of treatment being received. The issue of this form does not imply any liablity on the parts of AXA Cooperative Insurance.

Please Note: You are advised to keep a record of all information supplied in connection with this Application, including any letters you send us in connection with it. If you would like a copy of this application, please let us know within 3 months.

Send this claim form together with supporting material to:

Healthcare Department, AXA Cooperative Insurance, P.O.Box 21044, Riyadh 11475, Saudi Arabia, Tel: +966 1 478 0282, Fax: +966 1 477 3097