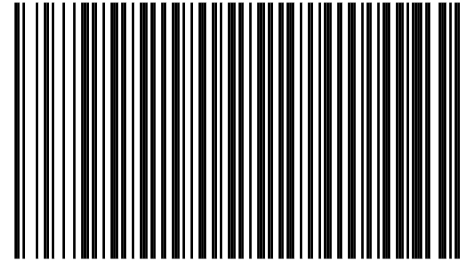


Claim Form

CLAIM DATE : 05/10/2021

Incident #:

11040942



G00061005323

Insured Member & Provider Details

| | | |
|--|---------------------------------|-----------------------------------|
| Member Name: DHUHA FAISAL S ALSAEDI | CID : 300092700876 | Member Mobile No. : |
| Affiliations/Doctor : | Policy No. : 5201 | Package : Fay Regional |
| Dr. Mohammad Sawi Mohammad Abdul Manaam | Auth Status : REGISTERED | Specialty : Prosthodontics |
| Provider Name : Al Maidan Dental Clinic (F26) | | |

Special Exclusions

Waiting Period

MATERNITY EXCLUDED

Chief Complaint & Symptoms

Date of Illness: / /2021 Chronic Acute Check Up Maternity LMP: / / /2021

Diagnoses & Treatments Details

| | | |
|-------------------|--------------|-----------------------------------|
| Primary ICD 10: | K02.9 | DENTAL CARIES, UNSPECIFIED |
| Secondary ICD 10: | | |

| Code | Description |
|------|-------------|
| | |

| Tooth # | Code | Description | Requested (Qty/Days) | Approved (Qty/Days) | Service Date | Req Amount KD | Appr Amount KD | Member Amount KD | VISA No. | Remarks |
|--------------|------|-------------------------------------|----------------------|---------------------|--------------|----------------|----------------|------------------|----------|---------|
| FDI11 | 0120 | Examination - Consultant/Specialist | 1 / 0 | 1 / 0 | 26/09/2021 | 20.000 | 20.000 | 4.000 | 19781604 | |
| FDI44 | 2331 | Composite 2 Surf. | 1 / 0 | 1 / 0 | 26/09/2021 | 40.000 | 40.000 | 8.000 | 19781604 | |
| FDI11 | 0330 | Panoramic X-Ray | 1 / 0 | 1 / 0 | 26/09/2021 | 12.000 | 12.000 | 2.400 | 19781604 | |
| FDI45 | 2331 | Composite 2 Surf. | 1 / 0 | 1 / 0 | 26/09/2021 | 40.000 | 40.000 | 8.000 | 19781604 | |
| FDI43 | 2331 | Composite 2 Surf. | 1 / 0 | 1 / 0 | 26/09/2021 | 40.000 | 40.000 | 8.000 | 19781604 | |
| Total | | | | | | 152.000 | 152.000 | 30.400 | | |

I hereby certify that All information mentioned IS correct and that the medical services on this form were provided and necessary for the management of this case

| | | |
|--|---|-------------------|
| Physician's Signature. | Stamp | Date : 05/10/2021 |
| <p>I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the mentioned expenses shall be absolutely forfeited.</p> <p>I further herby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person that has any record or information about me and/or any of my family members to provide GIG with the complete information's including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization.</p> <p>I agree that a copy of this consent shall have the validity of the original.</p> | <p>أقر انا بعلمي وموافقتي علي انه في حاله قيامي بالأداء ببيانات غير صحيحة أو خاطئة أو مخالفه للواقع وكذلك في حال كتمان أو إخفاء ايه بيانات تخص حالتني الصحية بأحقية مجموعته الخليج للتأمين بسقوط حقي في المطالبة بسداد النفقات بشكل كامل وتلقائي.</p> <p>كما أقر بموافقتي عل تفويض اي طبيب أو مقدم خدمه طبيه بتزويد مجموعته الخليج للتأمين بكل المعلومات الطبية الخاصة بي كامله بما فيها نسخ سجلات الملفات الطبية الخاصة بحالتي الصحية والتشخيص الطبي والفحوصات والعلاج بالمستشفيات .</p> <p>كما أقر بعلمي التام وموافقتي علي استخدام أي نسخه من هذا التفويض , وان اي نسخه منه تعتبر بمثابة نسخه أصليه.</p> | |
| Insured Member. | Stamp | Date : 05/10/2021 |