Claim Form

Seib
تأمين وإعادة تأمين
INSURANCE & REINSURANCE
Builders Of Trust | بُناة الثقة

CLAIMANT Details

Member's Name:

Membership #: **Staff #:**

Claimed Amount: **Primary Insured Mobile #:**

Treatment Date: **Email:**

Insurance Company

This form is applicable only for reimbursement claims resulting from:

1. Card under processing
2. Transaction not accepted by the Member of GlobeMed Qatar/SEIB Network

Provider Name:

3. Emergency Case and no GlobeMed Qatar/SEIB Network Available in the Geographical Area:
4. Emergency Abroad
5. Prior Approval delivered by GlobeMed Qatar/SEIB
6. Others:

Remarks:

CHIEF COMPLAINT/ DIAGNOSIS AND PROGNOSIS (to be filled in by the treating Physician)

Doctor's Name:

Address: **Tel/ Mobile #:**

Signature & Stamp:

How to make a reimbursement claim?

All Claims must include the following:

- **Original completed claim form**
- **Original itemized invoices and receipt(s) of payment**
- **Original detailed report such as:**
  - **Medical – specifying diagnosis and procedure**
  - **Dental – specifying services and tooth number. X-ray reports, as applicable.**
  - **Optical – specifying diagnosis and procedure / Eye test report from ophthalmologist**
  - **Detailed Discharge Report in case of hospitalization**
- **Original prescription for medicines, as applicable**
- **Photocopies of laboratory/diagnostic reports, if applicable**
- **Pre-authorization form, if applicable**
- **Pre-authorization form from GlobeMed Qatar/SEIB, for in-patient, day care, physiotherapy sessions or any claim exceeding QR 1,500**
- **For any pending claims, please note that missing documentation must be received within a maximum period of 3 months (90 days) within Qatar or 4 months (120 days) outside Qatar, otherwise the claim will be automatically rejected and file closed**

Note: All the above documents must be in either English or Arabic language only.

Please submit all claims for treatment incurred within Qatar – max 60 days from date of treatment.
For Claims incurred Outside Qatar – Max 90 days from date of treatment.
Seib reserves the right to reject any claims submitted later than this stipulated time frame.

I, the undersigned, on my own behalf/on behalf of the beneficiary named above, give permission to SEIB, the Administrative Agent and delegates (doctors and nurses) to verify my/the beneficiary's health status. I also authorize any doctor, nurse, hospital or health care institution, to provide SEIB, the Administrative Agent and delegates with all health information related to me/the beneficiary they are aware of or available in their files and medical records. For this purpose, I give up in my name/the beneficiary name my right for medical confidentiality to SEIB, the Administrative Agent and delegates.

Signature: **Date:**