Medical Claim Form

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 process
2. Transaction not accepted by Seib Insurance's network of medical providers
3. Medical treatment outside the Seib Insurance network
4. Emergency abroad
5. Prior approval obtained from Seib Insurance
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?

Claims must include the following

- Original completed claim form
- Original itemized invoices & receipt(s) of payment
- Original detailed report such as:
  - Medical – specifying diagnosis and procedure
  - Dental – specifying services & tooth number, X-ray report, if required
  - Optical – specifying diagnosis & procedure / eye test report from ophthalmologist
  - Detailed Discharge Summary
- Original prescription for medicines, if required
- Photocopies of laboratory/diagnostic reports, if required
- Pre-authorization form from Seib Insurance 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 will be closed

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

Please submit all claims for treatment incurred within Qatar – maximum 60 days from date of treatment. For claims incurred outside Qatar – maximum 90 days from date of treatment.
Seib Insurance 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 Insurance, the administrative agents 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 Insurance, the administrative agents 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's name my right for medical confidentiality to Seib Insurance, the administrative agents and delegates.

Signature	Date