Health 360°

NATIONAL CLAIM & APPROVAL FORM (DENTAL & OPTICAL)

When submitting the claim to Health 360°, this form must be attached along with the claim form and other supporting documents.
Please fax, email or submit online your prior apporval request to Health 360°,
Bahrain Hotline: +973 80011360, Fax: +973 17600588, Email: claims@health360.bh

SECTION A: MEMBER DETAILS *(TO BE FILLED BY THE INSURED MEMBER)*

Member Name: Gender: M F

Policy Number: ID. Number:

D.O.B File No. Mobile No. Date of Visit:

SECTION B: DENTAL SECTION *(TO BE FILLED ONLY BY THE TREATING DENTIST)*

1. Chief Complaint & Main Symptoms: ....
2. Duration of illness: ....
3. Diagnosis: ....
4. Please tick (✔) *where appropriate:*

RTA Work Related Accident Sports Related

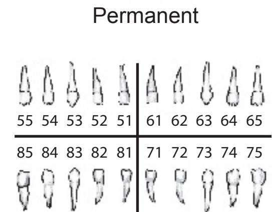
Orthodontics\Esthetics Congenital\Developmental Check-Up Cleaning

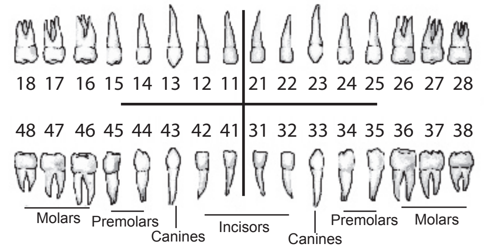
5. Anticipated plan of treatment/procedures:

....

....

Permanent





Service	Cost (BHD)
Doctors Fee	
Medicine	
X-Ray	
Dental Procedures (specify)	

Anticipated Total Cost: BHD

Anticipated Date of Rx

CONSULTATION / الإستشارة

SECTION C: OPTICAL SECTION *(TO BE FILLED ONLY BY OPTHALMOLOGIST/ OPTICIAN)*

RIGHT EYE							LEFT EYE						PD
	Sphere	Cylinder	Axis	Prism	V/A			Sphere	Cylinder	Axis	Prism	V/A	
Distance							Distance						
Near							Near						

Right Lens Cost

Left Lens Cost:

Frame Cost:

Anticipated Total Cost (BHD):

SECTION D: DECLARATION *(TO BE SIGNED BY ATTENDING PHYSICIAN AND THE MEMBER OR GUARDIAN)*

Member Declaration

I, the undersigned, hereby declare that the above mentioned services have been rendered to me in full and confirm that the settlements contained herein are true and that all relevant information has been disclosed. I hereby authorize my insurer/TPA to review my file if any further information or clarification is required. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the company of the claim and the company reserves the right to process or reject or require further/ additional information in respect of the claim.

Memeber Signature: ....

Date: ....

Medical Service Provider Declaration

I hereby certify that ALL information mentioned herein are correct & that the services shown on this form were medically indicated & necessary for the management of this case.

Name of Physician: ....

Registration No.: Expiry Date: dd/mm/yyyy

Signature: ....

Stamp: Date: ....

FOR INSURANCE COMPANY USE ONLY:

☐ Approved: (BHD) ☐ Not Approved: (BHD) Comments: ....

Approval No.: .... Approval Validity.: ....

Insurance Officer: .... Signature: .... Date: .... CLAIM No.