Health 360°

BIA

NATIONAL CLAIM FORM PRIMARY MEDICAL CARE

Clear Form | Print

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

CONSULTATION / الإستشارة

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

Member Name:	Insurance Company/ TPA Name:
Membership /Policy No:	Policy Holder:
Date of Birth: Gender: M ◯ F ◯	CPR/Passport Number:
Marital Status: Single ◯ Married ◯	Member's Phone Number:

SECTION B: MEDICAL SECTION *(TO BE FILLED ONLY BY THE TREATING PHYSICIAN)*

Please Tick: Inpatient ☐ Outpatient ☐ Emergency Case ☐	Provider Name:
Date of Treatment: (dd/mm/yyyy)	Medical Record No:
Pre Existing Condition: ☐ RTA ☐ Chronic Condition: ☐ Work Related Accident ☐ Maternity ☐ EDD ..... Others (please specify):	Vital Signs: Blood Pressure: Pulse: Temp:
Main Complaint & Presenting Symptoms:	Duration/History of illness:
Clinical Finding and Final Diagnosis: (use ICD codes as appropriate)	

PRE-AUTHORIZATION SECTION (MEDICAL & INVESTIGATION REPORT MUST BE ATTACHED WHERE APPLICABLE)

Plan of Management/ Treatment | Expected Date of Admission: | Anticipated Length of Stay:

Package Deal Code:	ANTICIPATED COST: (BHD)

Member Declaration

I the undersigned hereby certify that all statements & information provided concerning identification & the present illness or injury are TRUE. Furthermore, I authorize and request the Hospital to provide my Insurer / TPA with any information they request in connection with any treatment and / or services provided to me and grant them full access to my medical files. 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.

Name of Member: .....

Signature: .....

Date: .....

Medical Service Provider Declaration

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

Name of Physician: .....

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.