



Health 360°

NATIONAL CLAIM FORM PRIMARY MEDICAL CARE

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 approval 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:		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: <input type="text"/> (dd/mm/yyyy)	Medical Record No: <input type="text"/>
Pre Existing Condition: RTA	Vital Signs:
Chronic Condition: Work Related Accident	Blood Pressure:
Maternity EDD	Pulse:
Others (please specify):	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: <input type="text"/>	Anticipated Length of Stay: <input type="text"/>
Package Deal Code: <input type="text"/>	ANTICIPATED COST: (BHD) <input type="text"/>	

<p>Member Declaration</p> <p><i>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.</i></p> <p>Name of Member:</p> <p>Signature:</p> <p>Date:</p>	<p>Medical Service Provider Declaration</p> <p><i>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.</i></p> <p>Name of Physician:</p> <p>Physician Registration No.: <input type="text"/></p> <p>Expiry Date: (dd/mm/yyyy) <input type="text"/></p> <p>Signature:</p> <p>Stamp: _____ Date:</p>
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FOR INSURANCE COMPANY USE ONLY:

<input type="checkbox"/> Approved: (BHD) <input type="text"/>	<input type="checkbox"/> Not Approved: (BHD) <input type="text"/>	Comments:
Approval No.:	Approval Validity:
Insurance Officer:	Signature:	Date: CLAIM No. <input type="text"/>

الإستشارة / CONSULTATION