CHRONIC CLAIM FORM

ENAYA INSURANCE

GlobeMed Kuwait

Insured's Name: _____ Employee Name: _____

Civil ID #: _____ PF #: _____

Mobile #: _____ Contract & Individual # (Insurance card #): _____

Date of Visit: _____

(To be completed by the Attending Physician)

Doctor's Name: _____ Mobile #: _____

Specialty: _____

DURATION OF DISEASE

CHIEF COMPLAINT

TREATMENT PLAN

Medicine Name	Allowed Generic Substitute	Dose	Frequency	Duration

I the undersigned, hereby declare the following: I give full authorization to the Insurance Company and/or employer adhering to GlobeMed and its representatives to inquire about my past and actual state of health. I also authorize them to inform my attending physician, within their capacities, of the information available at their end about my state of health. Hence, I request from the healthcare provider to reveal and provide the Insurance Company and/or employer and GlobeMed and its representatives, with all available information concerning my person that are known to them or that are held in their files and medical records and photocopies of it.

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

PHYSICIAN'S SIGNATURE & STAMP

NAME **SIGNATURE** **DATE** ____ / ____ / ____