REIMBURSEMENT CLAIM FORM

ENAYA INSURANCE

GlobeMed Kuwait

Provider Name _____ Contract & Individual No _____

Adherent Name _____ CID# _____

Date of Visit _____ Mobile # _____

CHIEF COMPLAINT & MAIN SYMPTOMS

DIAGNOSIS

DURATION OF ILLNESS

◯ Maternity LMP: ◯ Chronic ◯ Acute ◯ Check up

OTHER CONDITIONS

DIAGNOSIS (ICD10): PLEASE CHECK WHERE APPROPRIATE

Respiratory System
- ◯ Allergic Rhunitis J30.4
- ◯ Asthma J45.9
- ◯ Bronchitis J20.9
- ◯ Cough R05
- ◯ COPD J44.8
- ◯ Dyspnea R06 0
- ◯ Hypertrophied Adenoids & Tonsils J35.3
- ◯ Pneumonia J18.9
- ◯ Sinusitis J01.9
- ◯ Tonsillitis J03.9
- ◯ URTI J06.8

Endocrine Metabolic
- ◯ Diabetes E14.9
- ◯ Dyslipidemia E78.5
- ◯ Goitre E04.9
- ◯ Gout M10.99
- ◯ Hyperthyroidism E05.9
- ◯ Hypothyroidism E03.9
- ◯ Iron Deficiency D50.9
- ◯ Hormonal disorders E35.8
- ◯ Vitamine D Deficiency E55.9
- ◯ Obesity E66.9

Digestive system
- ◯ Abdominal pain R10.4
- ◯ Crohn's Disease K50.9
- ◯ Diarrhea A09
- ◯ GERD K21.9
- ◯ Irritable Bowel Syndrome K58.9
- ◯ Nausea & Vomiting R11
- ◯ Ulcer, peptic or duodenal K27.9

Blood/Immunity
- ◯ Immunity D89.9
- ◯ Anemia D64.9

Genitourinary system
- ◯ Acute Vaginits N76.8
- ◯ Breast Lump N63
- ◯ Calculus of Kidney & Ureter N20.9
- ◯ Dysuria R30.0
- ◯ Haematuria R31
- ◯ Hyperplasia of Prostate N40
- ◯ Menopausal & premenopausal disorders N95.9
- ◯ Ovarian cyst N83.2
- ◯ PCO E28.2
- ◯ Renal colic N23
- ◯ Urinary Incontinence R32
- ◯ UTI N39.0
- ◯ Vaginal bleeding N93.9

Skin & subcutaneous tissue
- ◯ Acne L70.9
- ◯ Dermatitis L30.9
- ◯ Cellulitis & Abscess L03.9
- ◯ Hair Loss L65.9
- ◯ Naevus I78.1
- ◯ Skin tags L91.9
- ◯ Urticaria L50.8
- ◯ Warts B07

Circulatory
- ◯ Angina pectoris I20.9
- ◯ Arrhythmias I49.9
- ◯ Chest Pain R07.4
- ◯ Chronic Ischemic Heart Disease I25.9
- ◯ Hypertension I10
- ◯ Palpitation R00.2
- ◯ Varicose Veins I83.9
- ◯ Varicocele I86.8
- ◯ Pregnancy Z32.1

CNS
- ◯ Headache R51
- ◯ Epilepsy G40.9
- ◯ Migraine G43.9
- ◯ Multiple Sclerosis G35
- ◯ Vertigo H81.3
- ◯ Polyneuropathies G60.9

Musculoskeletal system
- ◯ Cervicalgia M54.2
- ◯ Derangement Of Knee M23.89
- ◯ Lumbago M54.5
- ◯ Osteoporosis M81.99
- ◯ Pain in joints M25.59

Eye & adnexa
- ◯ Cataract H26.9
- ◯ Conjunctivitis H10.9
- ◯ Chalazion H00.1
- ◯ Glaucoma H40.9

Ear & mastoid
- ◯ Labyrinthitis H83.0
- ◯ Otitis Media H66.9
- ◯ Otitis Externa H60.9
- ◯ Impacted cerumen H61.2

Infectious & Parasitic
- ◯ Fever R50.9
- ◯ Gastroenteritis A09
- ◯ Genital Warts A63.0
- ◯ Hepatits B19.9
- ◯ Infectious & Parasitic B89

Others
- ◯ Conditions originating in the perinatal period P96.9
- ◯ Congenital malformations Q89.9
- ◯ Injury & poisoning 19
- ◯ Infertility, Male N46
- ◯ Infertility, Female N97.9
- ◯ Neoplasms D48.9

Out Patient Service (Description)	Currency	Cost	Medications	Currency	Cost

I the undersigned, hereby declare the following: I give full authorization to the Insurance Company and/or employer adhering to GlobeMed system and 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 SIGNATURE & STAMP

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

REIMBURSEMENT DENTAL CLAIM FORM

ENAYA INSURANCE

GlobeMed Kuwait

Provider Name | Patient File # | Adherent name

Insurance Co | Mobile # | Individual Number

Date of Visit | CID # | Policy Holder

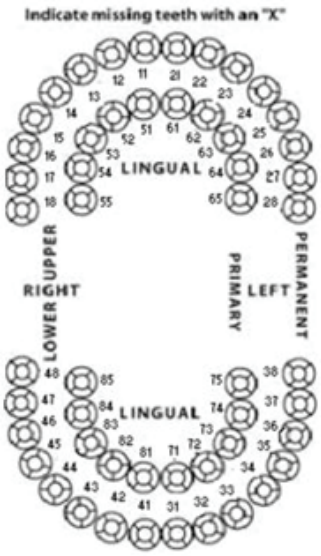
(to be completed by the dentist)
DURATION OF DISEASE

CHIEF COMPLAINT & MAIN SYMPTOMS

PLEASE CHECK WHERE APPROPRIATE

◯ RTA ◯ Cleaning ◯ Work Related Accident ◯ Sports Related ◯ Check-Up ◯ Congenital\Developmental ◯ Orthodontics\Esthetics

Type of Treatment	Tooth No./Letter	Cost
Extraction		
Neurectomy		
X-ray		
Cleaning		
Bridge		
Dentures		
Filling		
Gum Treatment		
R.C.T		
Scaling		
Orthodontics		
Crowns		
Prophylaxis		
Others		
TOTAL CLAIMED AMOUNT		



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NAME **SIGNATURE**

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.

Dr.

DENTIST SIGNATURE & STAMP

DATE ____ / ____ / ____

DOCUMENTS NEEDED FOR REIMBURSEMENT CLAIMS

ENAYA INSURANCE

GlobeMed Kuwait

DOCUMENTS NEEDED FOR DOCTOR VISIT, AMBULATORY TESTS AND HOSPITALIZATION REIMBURSEMENT CLAIMS

1. Detailed Medical Report signed and stamped by the treating physician (Diagnosis, complaints, past medical history, duration of illness and other conditions).
2. Detailed original invoice i.e. cost per item.
3. Results for all tests done e.g. labs, radiology, cytopathology... etc.
4. Discharge summary for in-patient cases.

المستندات المطلوبة لإعادة تسديد زيارة الطبيب والفحوصات الخارجية وحالات الاستشفاء داخل المستشفى

1. تقرير طبي مفصل موقع ومختوم من قبل الطبيب المعالج يشرح وضع المريض الصحي (التشخيص، شكوى المريض، بداية ظهور الاعراض او الحالة المرضية، التاريخ المرضي السابق و اي حالات اخرى)
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.
3. نتائج التحاليل المخبرية والاشعة وتحاليل الانسجة (الباثلوجيا الخلوية) ...الخ.
4. التقرير النهائي عند خروج المريض من المستشفى (فقط في حالة الاقامة داخل المستشفى للحالات المرضية او الجراحية)

DOCUMENTS NEEDED FOR PRESCRIPTION MEDICINE REIMBURSEMENT CLAIMS

1. Original prescription or a stamped copy of the prescription in case the prescribed medicines are antibiotics or steroids.
2. Detailed original invoice i.e. cost per item.

المستندات المطلوبة لإعادة تسديد الأدوية موضوع وصفة طبية

1. الوصفة الأصلية أو صورة مختومة بخاتم الصيدلية في حالة وصفات المضادات الحيوية ومركبات الكورتيزول.
2. فاتورة اصلية مفصلة محدد فيها سعر كل دواء.

DOCUMENTS NEEDED FOR DENTAL TREATMENT REIMBURSEMENT CLAIMS

1. Panoramic X-ray
2. Detailed original invoice i.e. cost per item.

المستندات المطلوبة لإعادة تسديد علاج الاسنان

1. الأشعة السنية (Panoramic).
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.

A copy of the insurance card and the Civil ID should be enclosed.

يجب ان يرفق مع كل طلب صورة عن بطاقة التأمين والبطاقة المدنية.