P.O.Box. 2907, Ruwi, Postal Code:112, Sultanate of Oman

**OUT PATIENT REIMBURSEMENT CLAIM FORM**

*(Please give the information correctly and completely)*

| | | |
|---|---|---|
| 1 | Policy Number | |
| 2 | Name of the Patient | |
| 3 | Name of the Employer | |
| 4 | Employee Number | |
| 5 | Nature of illness/disease | |
| 6 | Date of Injury/illness first detected | |
| 7 | Duration of the Ailment | |
| 8 | Whether this claim is made of Pre& Post treatment, if yes please provide the details of main claim. | |
| 9 | Period of Treatment | From: To: |
| 10 | Name of the Hospital | |
| 11 | Address of the Hospital | |
| 12 | Total Claimed Amount | |

Signature of the Employee: Date:
Place:
I/We hereby declare that the particulars made by the injured person in the claim form are true to the best of our knowledge and belief.

Signature of the Employer: Date:
Place:


P.O.Box. 2907, Ruwi, Postal Code:112, Sultanate of Oman

**IN PATIENT REIMBURSEMENT CLAIM FORM**

*(Please give the information correctly and completely)*

| | | |
|---|---|---|
| 1 | Policy Number | |
| 2 | Name of the Patient | |
| 3 | Name of the Employer | |
| 4 | Employee Number | |
| 5 | Nature of illness/disease | |
| 6 | Date of Injury/illness first detected | |
| 7 | Duration of Ailment | |
| 8 | Whether this claim is made for Pre & Post Hospitalization, if yes please provide the details of main claim. | |
| 9 | Place of treatment | |
| 10 | Date of Admission: | Date of Discharge: |
| 11 | Name of the Hospital | |
| 12 | Address of the Hospital | |
| 13 | Total Claimed Amount | |

Signature of the Employee: Date:

Place:

I/We hereby declare that the particulars made by the injured person in the claim form are true to the best of our knowledge and belief.

Signature of the Employer: Date:

Place: