

- **Dear Doctor**, we thank you for filling in medical sections **B** of this claim form and for signing, dating and stamping it.
- **Dear Member**, we thank you for completing sections **A** of this claim form and for signing and dating it. **All fields on the page are compulsory. Claim Must Be Submitted Within 30 Days.**



**Tacawun**  
Cooperative Insurance  
مؤمنة تعاونية

## MEDICARE TACAWUN REIMBURSEMENT CLAIM FORM

### PART A: To be completed by the Patient / Principal Member

Patient's Name		Membership No	
Employee's Name		Relation	
Employer's Name		Mobile No	
Is the claim covered by other Insurance? If Yes, please enclose details			Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you get admitted for this kind of illness in any Hospital within last three months' time?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, mention the name of the Hospital			
<b>Payment Method</b>	<input type="checkbox"/> Bank Payment <input type="checkbox"/> Remittance		
<b>If Selected Bank Payment</b>	Account Name:		
	Account No		
<b>Bank Name:</b>		<b>Bank Address</b>	
<b>If Selected Remittance</b>	<b>Name</b>		
	<b>Mobile No</b>		<b>Location</b>

**DECLARATION:** I confirm that the information I have given on this form is accurate, to the best of my knowledge. I hereby authorize TIA to discuss, access and obtain a copy of my health records (or any of my dependents' records) that may be requested by them or their appointed representative. I also agree that a copy of this declaration stands valid as original. I understand that in the event that terms and conditions of my plan have not been met Hospital reserves the right to recover any costs directly from the plan holder or myself.

**Signature of Patient/Principal Member**

Signature

Date

### PART B: To be completed by the Attending Physician or Treating Doctor

<input type="checkbox"/> Sickness (State)	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic	<input type="checkbox"/> Congenital/Hereditary	<input type="checkbox"/> Work Related	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Accident (State Nature of Injuries:					
<input type="checkbox"/> New Visit	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Outpatient(OP)	<input type="checkbox"/> Emergency OP	<input type="checkbox"/> Day Care	<input type="checkbox"/> Dental <input type="checkbox"/> Optical
<b>In case of IN-PATIENT admission</b>	<b>Admission Date</b>		<b>Discharge Date</b>		
<b>Diagnosis and Findings</b>					

### PHYSICIAN/DOCTOR'S DECLARATION

I hereby certify that all medical information mentioned is to the best of my knowledge true and the medical services shown on this form are medically indicated & necessary for the management of the patient medical condition.

**Treating Doctor's Name:**

**Specialty:**

**Contact No.:**

**Doctor's Signature & Stamp:**