

Summary Sheet for Reimbursement Claims

Administrative Part:

Name of Patient	
Card Number	
Date of Birth	
Contact Number	
Category	
IBAN / Bank Info	

Initial Submission Resubmission

Inpatient Requirements:

- | | YES | NO |
|---|-----------------------|-----------------------|
| 1. Completely filled Reimbursement ASOAP form signed and stamped by treating physician and member_____ | <input type="radio"/> | <input type="radio"/> |
| 2. Results of all laboratory and radiology investigations_____ | <input type="radio"/> | <input type="radio"/> |
| 3. Original prescription_____ | <input type="radio"/> | <input type="radio"/> |
| 4. Original invoices with itemizations of specific services availed_____ | <input type="radio"/> | <input type="radio"/> |
| 5. Complete discharge summary with course in the ward. In case surgery was done, intraoperative notes and findings should be provided._____ | <input type="radio"/> | <input type="radio"/> |
| 6. In case of injury and trauma please provide details as to how, when and where it happened_____ | <input type="radio"/> | <input type="radio"/> |
| 7. Official receipt corresponding to all the charges and bills_____ | <input type="radio"/> | <input type="radio"/> |
| 8. English Translation for claims other than Arabic_____ | <input type="radio"/> | <input type="radio"/> |
| 9. Pre-approval from Insurance company if required by policy_____ | <input type="radio"/> | <input type="radio"/> |

Outpatient Requirements:

- | | | |
|--|-----------------------|-----------------------|
| 1. Completely filled reimbursement ASOAP form signed and stamped by treating physician and member_____ | <input type="radio"/> | <input type="radio"/> |
| 2. In case of injury and trauma please provide details as to how, when and where it happened_____ | <input type="radio"/> | <input type="radio"/> |
| 3. Results of all laboratory radiology investigations_____ | <input type="radio"/> | <input type="radio"/> |
| 4. Original prescription_____ | <input type="radio"/> | <input type="radio"/> |
| 5. Original invoices with itemizations of specific services availed_____ | <input type="radio"/> | <input type="radio"/> |
| 6. Official receipt corresponding to all the charges and bills_____ | <input type="radio"/> | <input type="radio"/> |
| 7. Optical Prescription for optical claims in addition to above documents_____ | <input type="radio"/> | <input type="radio"/> |
| 8. Dental reports with tooth number specified for Dental in addition to above documents_____ | <input type="radio"/> | <input type="radio"/> |
| 9. English Translation for claims other than Arabic_____ | <input type="radio"/> | <input type="radio"/> |
| 10. Pre-approval from insurance company if required by policy_____ | <input type="radio"/> | <input type="radio"/> |

Documents complete YES: NO:

Checked by: _____

Date: _____