Health 360° BIA

NATIONAL CLAIM & APPROVAL FORM (DENTAL & OPTICAL)

Clear Form | Print

When submitting the claim to Health 360°, this form must be attached along with the claim form and other supporting documents. Please fax, email or submit online your prior apporval request to Health 360°,
Bahrain Hotline: +973 80011360, Fax: +973 17600588, Email: claims@health360.bh

SECTION A: MEMBER DETAILS *(TO BE FILLED BY THE INSURED MEMBER)*

Member Name: _____ Gender: ◯ M ◯ F

Policy Number: _____ ID. Number: _____

D.O.B _____ File No. _____ Mobile No. _____ Date of Visit: _____

SECTION B: DENTAL SECTION *(TO BE FILLED ONLY BY THE TREATING DENTIST)*

1. Chief Complaint & Main Symptoms: .....

2. Duration of illness: .....

3. Diagnosis: .....

4. Please tick (✔) *where appropriate:*

☐ RTA ☐ Work Related Accident ☐ Sports Related

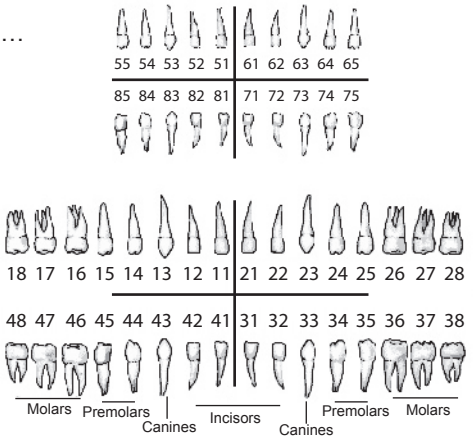
☐ Orthodontics\Esthetics ☐ Congenital\Developmental ☐ Check-Up ☐ Cleaning

5. Anticipated plan of treatment/procedures:

.....

.....

Permanent



Service	Cost (BHD)
Doctors Fee	
Medicine	
X-Ray	
Dental Procedures (specify)	

Anticipated Total Cost: BHD _____ Anticipated Date of Rx: _____

SECTION C: OPTICAL SECTION *(TO BE FILLED ONLY BY OPTHALMOLOGIST/ OPTICIAN)*

	RIGHT EYE						LEFT EYE						PD
	Sphere	Cylinder	Axis	Prism	V/A		Sphere	Cylinder	Axis	Prism	V/A	
Distance						Distance							
Near						Near							

Right Lens Cost | Left Lens Cost:

Frame Cost: | Anticipated Total Cost (BHD):

SECTION D: DECLARATION *(TO BE SIGNED BY ATTENDING PHYSICIAN AND THE MEMBER OR GUARDIAN)*

Member Declaration

I, the undersigned, hereby declare that the above mentioned services have been rendered to me in full and confirm that the settlements contained herein are true and that all relevant information has been disclosed. I hereby authorize my insurer/TPA to review my file if any further information or clarification is required. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the company of the claim and the company reserves the right to process or reject or require further/ additional information in respect of the claim.

Memeber Signature: .....

Date: .....

Medical Service Provider Declaration

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

Name of Physician: .....

Registration No.: _____ Expiry Date: _____ dd/mm/yyyy

Signature: .....

Stamp: Date: .....

FOR INSURANCE COMPANY USE ONLY:

☐ Approved: (BHD) _____ ☐ Not Approved: (BHD) _____ Comments: .....

Approval No.: ..... Approval Validity.: ....

Insurance Officer: ..... Signature: ..... Date: ..... CLAIM No. _____

CONSULTATION / الإستشارة