Forward together

شركة عمان للتأمين
Oman Insurance Company

Reimbursement Claim Form
Healthcare Insurance

.One Claim Form per person, family members must apply individually
. For the required supporting documentation, use the attached Summary Table as cover sheet
. Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections
Please submit the form within 30 days of treatment to ensure timely processing. Only original claim forms will be accepted as each form carries a unique form number. To download a form, please visit our website www.tameen.ae

1. Claimant Details		Form Number	58692588
Claimant Name			
Card Number		Mobile No.	0 5
Email Address			

2. Principal Member Bank Details (in case not provided already or needs to be updated)			
Account Name		Bank A/C #	
Bank Name		Branch	
IBAN (23 digits)			

3. Claim Details

Is the claim in UAE?	☐ Yes	☐ No	If No, precise Country		
Name of Hospital/Dr.					
Date of Treatment	/ / 1		Number of Invoices		
Total Amount Claimed			Currency		

For breakdown of Total Amount Claimed, use attached summary table cover sheet to tabulate entries in chronological order.

4. Medical Details – to be completed by the treating Doctor

Is it work related?	☐ Yes	☐ No	If Yes, specify	
Treatment Type	☐ In-Patient	☐ Out-Patient	☐ Day Care	
Chief Complaint				
Diagnosis				
Treatment Details				

I, the undersigned treating doctor, hereby declare I have attended to this patient and the particulars provided are correct and accurate to the best of my knowledge.

Doctor Name & Stamp		Signature		Date	

5. Claimant's Declaration & Authorization

I confirm that all particulars filled are true, accurate and complete. I hereby authorize (i) the medical provider/other entities to provide & discuss health/treatment details with Oman Insurance Company ('Insurer') and/or its third party administrator (ii) the Insurer to (a) disclose my personal/claim information for claim processing or as may be required (b) to use alternate claim payout option if required (iii) contact me for claim/other products information. I understand that (i) any person, who intentionally conceals, makes false or misleading statement to obtain claim reimbursement, is subject to penalization and legal action (ii) acceptance of claim form does not constitute acceptance of liability by the Insurer (iii) my claim is subject to terms and conditions of my policy. This authorization shall remain valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorization shall be as valid as the original.

Claimant Name		Signature		Date	

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Summary Table of Invoices
Reimbursement Claim Form Attachment

Mark the sequence number of the corresponding invoice.

Sequence Number	Service Date	Provider Name	Service Description	Invoice ref. Number	Claimed Amount	Currency

In case you have more invoices to send, please photocopy this sheet.

Checklist - Before you submit, please check that you have included all of the following as applicable:	✓
1. Completed, stamped and signed Reimbursement Claim Form	
2. Original invoices/bills showing payments confirmation	
3. Medical and/or Lab test reports	
4. All claims submitted must be in original & translated to either English or Arabic for the settlement	
5. Healthcare Insurance card copy of the claimant	
6. Summary Table of Invoices (above) completed	
7. You have retained a copy of the Form, Summary Table and original invoices and report for your reference	

Claimant Name & Signature

Member Name | Signature | Date