Q Life & Medical Insurance Company LLC
Incorporated at Qatar Financial Centre - License No. 141, Authorized by QFC Regulatory Authority (A **QIC** Group Company)

Preapproval Code [ ]

Direct Billing Claim Form

Provider: **Medical Record No.:** **Date:** dd / mm / yyyy

Patient Name: **Age/DOB:**

MEM: *Mandatory* **Qatari/Civil ID:** **Gender:** ☐ **F** ☐ **M**

Marital Status: **Policy Holder:** **Policy No.:**

☐ **New Visit** ☐ **Follow-up** ☐ **OP** ☐ **ER** ☐ **Day care** ☐ **IP**

In case in-patient admission is recommended, **Admission Date:** dd / mm / yyyy **Length of Stay:**

To be filled by Medical Practitioner

Present Illness Details:

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Past Medical History:

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☐ **Acute** ☐ **Chronic** ☐ **Accident** ☐ **Hereditary/Congenital** ☐ **Work Related** ☐ **Pregnancy** **LMP:** dd / mm / yyyy

Diagnosis: *Mandatory*

Duration of Illness: *Mandatory*

Lab / Radiology:

Code	Procedure
.....	.....
.....	.....
.....	.....

Medical Practitioner 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 Physician:

Specialty:

Contact No.:

Signature or Stamp:

Patient Declaration

I hereby certify that the entire particulars given above are true. I hereby authorize QLM Insurance Company 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.

Patient/Guardian Signature: **Date:** dd / mm / yyyy

Mobile No.: