Medical Authorization Centre: 800 6626
General Inquiries: 800 4746

Forward together

شركة عمان للتأمين
Oman Insurance Company

Inpatient Claim Form
Direct Billing - Healthcare Insurance

One Claim Form per person.
Section 3 & 4 to be filled by treating doctor & Section 5 by patient. All other sections to be filled by Administrative Personnel.
Please write in BLOCK LETTERS. In case additional details need to be provided, please photocopy this sheet.

1. Provider Details		Claim Form Number:	1379197
Provider Name		Facility License Code	

2. Member/Patient Details			
Card Number		Date of Birth (dd/mm/yyyy)	
Patient's Name (as it appears on the card)			
Telephone Number		Gender	☐ Male ☐ Female
Medical Record Number			
Reason for Visit	☐ Emergency ☐ New visit	☐ Road traffic accident ☐ Follow up	☐ Work related accident ☐ Referral
Referral source			

3. Medical Section			
Chief complaint & duration			
First consultation date for above condition (dd/mm/yyyy)			
Admitting Diagnosis			
ICD Code(s)			
Discharge Diagnosis			
Treatment Details			
CPT Code(s)			
Actual/Expected Date of Admission (dd/mm/yyyy)		Days of stay	

4. Doctor's Declaration

I declare that I am the patient's treating doctor and the particulars given are true and correct to the best of my knowledge.

Doctor's Stamp: Signature: Date:

5. Patient's Declaration

I confirm that all particulars above are true. I hereby authorize (i) the medical provider and any other entity to provide and discuss health/treatment details with Oman Insurance Company and/or third party administrator (ii) Oman Insurance Company to (a) disclose my personal/claim information for claim processing or as may be required (b) contact me for claim/other products information. I agree that a copy of this consent shall have the validity of original.

Name: Signature: Date: