Medical Authorization Centre: 800 6626
General Inquiries: 800 SUKOON (785666)

SUKOON™ INSURANCE

DIRECT BILLING - HEALTHCARE INSURANCE

INPATIENT CLAIM FORM

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

1. Claim Form Number	
2. Provider Name	
3. Facility License Code	

2. Member/Patient Details

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

3. Medical Section

1. Chief complaint & duration			
2. First consultation date for above condition (dd/mm/yyyy)			
3. Admitting Diagnosis			
4. ICD Code(s)			
5. Discharge Diagnosis			
6. Treatment Details			
7. CPT Code(s)			
8. 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 Sukoon Insurance PJSC (hereinafter referred to as "Sukoon") and/or third party administrator (ii) Sukoon 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