



شركة وربة للتأمين ش م ك  
WARBA INSURANCE COMPANY K.S.C

Ahmad Al-Jaber Street, PO Box:24282, Safat 13103 Kuwait  
Ph No (965) 808181 Fax 2466131  
Email : arogyam@warbaonline.com Website: www.warbaonline.com

**AROGYAM HEALTH INSURANCE CLAIM FORM**

**INPATIENT / PRE & POST HOSPITALIZATION CLAIM FORM**

Issuance of this form does not amount to admission of any liability under the claim on the part of the Insurers.  
Please give the following information correctly and completely to enable to process claim properly.

1) Name of the Company / Main Member .....  
(In whose name policy is issued, Name of the Company in case of Group Policy)

2) Details of the Insured Member (In respect of whom claim is made) .....

Patient's Name and Address :	Membership No.	
	Relationship with the insured	
Policy No.	Date of Birth	
Other Insurance Coverage - Yes/No (If yes attach details)	Gender (Male/Female)	
Employee Number (Group Policy) :	Telephone No.	

3) Name & Address of the Hospital :

4) Date of Admission / Service : ..... Date of Discharge : .....

5) Claimed Amount : ..... Currency : .....

**TO BE COMPLETED BY TREATING DOCTOR**

IP  PRE  POST

6) Diagnosis : .....
7) Details of Disease/illness contracted or injury suffered .....
Acute ( ) Chronic ( ) Congenital ( ) Others( )
8) Date of Injury sustained or Disease/illness first detected .....
9) Investigations done : .....
10) Treatment Given : .....
11) Name of the Doctor : .....
12) Sign & Stamp of Doctor : Telephone No. ....

\* In case of reimbursement claims, claim form and all documents may be submitted to TPA within the prescribed time.

In case of direct billing if a claim gets rejected due to any reason the amount will be repaid to Insurer by Insured within 15 days of receipt of notice.

**Member's / Hospital's Declaration**

I /We hereby warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We made or shall make any false or untrue statement, suppression or concealment, my/our right to claim reimbursement of the said expenses shall be absolutely forfeited. I/We hereby authorize Warba / Wapmed or their authorized representatives to check all the medical records related to treatment from the doctor/Hospital.

Member's Signature

Hospital's Signature

Date

Stamp of Hospital

**WAPMED ADDRESS**

WAPMED TPA Services Co., P. O. Box 26739, Safat 13128, Kuwait. Telephone 2466248, Fax: 2466234,  
Email : info@wapmed. Website: www.wapmed.net