

PREVIOUSLY AXA

When submitting your claim, this form must be attached along with the claim form and other supporting documents.

For NP: DHPO - mb.emergency@gig-gulf.com

Mem: intl@gig-gulf.com to confirm cover on consultation basis

Claiming: APP / Web

Hospital name:	Contact no:	Date received:
Physician name:	Contact no:	No. of pages:

 **Approval request for** (Please tick appropriate box)

In-patient
 Daycare
 Out-patient surgery
 Physiotherapy
 MRI/CT Scan
 Dental
 Maternity


Other, please specify:

 **Administrative section**

Company name:

DHA member no.:	Membership no.:	
Patient name:	Patient date of birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Policy/Group no:	Patient phone:	
Date of admission:	Date of discharge:	

In the case of emergency admission: (Details about Cause, Date, Place of accident)

 **Medical section**

Symptoms presented	Please state the date when the patient first became aware of any signs or symptoms for this condition	Please state the date of when the patient first visited a doctor for this condition
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Details of medical condition:

Full details of proposed treatment/surgery:

