CHRONIC CLAIM FORM

GlobeMed
Qatar

Insured's Name | Employee # | Contract Number

Insurance Co | Mobile # | Individual Number

Date of Visit | CID # | Policy Holder

(To be completed by the Attending Physician)

Doctor's Name | Mobile # | Specialty

DURATION OF DISEASE

CHIEF COMPLAINTS

TREATMENT PLAN

Medicine Name	Allowed Generic Substitute	Dose	Frequency	Duration

I the undersigned, hereby declare the following: I give full authorization to the Insurance Company and/or employer adhering to GlobeMed and its representatives to inquire about my past and actual state of health. I also authorize them to inform my attending physician, within their capacities, of the information available at their end about my state of health. Hence, I request from the healthcare provider to reveal and provide the Insurance Company and/or employer and GlobeMed and its representatives, with all available information concerning my person that are known to them or that are held in their files and medical records and photocopies of it.

NAME **SIGNATURE**

I hereby certify that ALL information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

Dr.

Physician SIGNATURE & STAMP

DATE ____ / ____ / ____