Medical & Dental Claim

Human Resources - Form

Employee Name		Employee No.	
Department /Section		Phone Ext.	

Date (dd/mm/yy)	Paid Amount (SAR)	Name of Patient	Self/ Relationship to Employee	Medical Facility	% Covered (To be filled by Co. Physician)
Total Amount Claimed (SAR)					

Note: *Original prescription, invoices and receipts should be attached. These should indicate the name of patient, name of facility that provides the treatment. Completed medical claim form along with the supporting documents is to be sent to the company physician for review and further processing.*

Employee Signature **Date**

Company Physician Authorization and Remarks

Physician's Signature **Date**

HR use only: Total amount to be reimbursed:	

HR Approval **Date**