ملحق رقم (3)

نموذج طلب الموافقات والمطالبات لخدمات العيون

OCAF

ملحق رقم (3): نموذج طلب الموافقات والمطالبات لخدمات العيون

Appendix no. (3): OCAF

إشارةً إلى الملحق رقم (2) من اللائحة التنفيذية لنظام الضمان الصحي التعاوني لمعايير طلب الموافقة على تحمل تكاليف العلاج، التي أوضحت الإجراءات المتبعة في حال طلب الموافقة من قبل المرافق الصحية ومسئوليات شركات التأمين للالتزام بما ورد فيها. النموذج الموحد يجب أن يتضمن جميع المعلومات الأساسية المذكورة فيه وأن يتم الالتزام بمعايير الترميز المعتمدة من المجلس وأن تكون الخدمات حسب قوائم الأسعار المتفق عليها حسب النموذج رقم (6). هذا النموذج يجب أن يكون جزء من متطلبات المطالبة التي ترسل من قبل المرفق الصحي إلى شركة التأمين.	Referring to Appendix No. (2) of the executive regulations of CCHI for the criteria of requesting approval to bear the costs of treatment, which clarified the procedures followed in the event that approval is requested by healthcare providers and the responsibilities of insurance companies to comply with what is stated therein. The Optical form must include all the basic information mentioned in it, the coding standards approved by the council must be adhered, and the services must be according to the price lists agreed upon according to form No. (6) in this contract. This form should be part of the claim requirements that are sent by the healthcare providers to the insurance company.

OCAF 2.0

To be completed by the reception/nurse:

Provider Name:

Insurance Company Name:

TPA Company Name:

Patient File Number:

Data of visit / /

Plan Type ( ) New visit ( ) I Follow Up ( )

Print/Fill in letters or Emboss Card:

Insured Name:

ID. Card No. Sex Age

Policy Holder Policy No

Expiry Data / /

Class Approval

To be completed by the Optician:

	RIGHT EYE					LEFT EYE					
	Sphere	Cylinder	Axis	Prism	V/N	Sphere	Cylinder	Axis	Prism	V/N	PD
Distance											
Near											

Bifocal	Add	Vertex	Add	Bifocal	Add

Regular Lenses Type:

☐ Glass ☐ plastic ☐ none

Lenses Specification:

☐ Multi – coated ☐ Medium ☐ Anti- reflecting coating

☐ Varilux ☐ Lenticular ☐ Photosensitive

☐ Light ☐ Single Vision ☐ High Index

☐ Aspheric ☐ Dark ☐ Colored

☐ Bifocal ☐ Safety Thickness ☐ Anti - Scratch

Contact Lenses Type:

☐ Permanent ☐ Disposal

Frames: ☐ **Yes** ☐ **No**

Please specify # of pairs:…….

Estimated Cost:

Leases: SR. ……..

Frame: SR. ……..

I hereby certify that All information mentioned are correct and that the services shown on this form were medically indicated and necessary for of this case.

Optician Signature & Stamp

Data / /

I hereby certify that All statements and information provided concerning patient identification and the present illness or injury are TRUE.

Name and relationship (if guardian):

Signature (*) Data / /

For Insurance Company Use Only: Approved ( ) Not Approved ( ) Approval No: Approval Validity:

Comments (include approved days/services if different from the requested)

Approved/Disapproved by **Signature** **Data / /**