Reimbursement Claim Form

استمـــارة التعـــويض

Tel: +9714 5591311 Fax: +9714 434 2310, Help Line for 24 Hours: 80043444 (Toll Free), 04 5591322

Date: / /	Healthcare Provider:

PATIENT INFORMATION

Patient's Name (as on card): *(Exactly as on Almadallah Card/Emirates ID)*	Mobile Number:

Card # | | | | | | | | Policy No. | | | | | | | | Birth date: / / (dd mm yy) Sex: ❑ M ❑ F

Reason for Not using Almadallah Healthcare Facilities: ❑Emergency ❑Family Doctor ❑Preferred Personal Choice

❑Service not available ❑on vacation/business trip outside UAE ❑ Other(s) please specify_____

CLAIMS PAYMENT DETAILS

Payment Preferable Method	❑ Bank Transfer to Account*	❑ Cheque

**If you have opted Bank Transfer Payment Mode, kindly login to your online account and enter bank details within 3 days of claim submission.*

INFORMATION

To be completed by Physician

Date of present symptoms: / / (dd mm yy)	Symptom(s) as described by Patient:

Pre-existing Condition(s) being treated for:	❑ No	❑ Yes	If Yes _____
Chronic Medications:	❑ No	❑ Yes	Specify: _____
Family History of any Illness:	❑ No	❑ Yes	_____

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Findings:

Cause ❑ Physical Illness ❑ Accident ❑ Maternity ❑ Preventive ❑ Psychiatric ❑ Dental ❑ Work Related

❑Other(s), Explain:

Assessment/Diagnosis	❑ Acute	❑ Chronic	❑ Confirmed	❑ Suspected
1-				
2-				

MEDICAL PLAN *(itemized original invoices & applicable prescriptions/ reports/ results must be enclosed to consider the claim)*

Type of Service	Name & Address of Provider	Service Date	Amount	Bill No.
Currency (if treatment availed outside UAE)_____			Total	

IN-PATIENT *(discharge summary, itemized invoices, report, results should be attached)*

Length of stay:	Provider:	Cost:

The above information is true to the best of my knowledge. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical conditions & history to **ALMADALLAH** for the purpose of determining insurance benefits

Treating Physician Name:	***Patient/Guardian signature***
Tel./Fax:	
✍Signature & Stamp	
Date:	*Date:*