

Reimbursement Claim Form

1. Daman Member Details and Contact Information	
Name:*	
<i>(Exactly as on the Daman card)</i>	
Daman Card No:	Mobile No.:*
Emirates ID (EID):*	
E-mail Address:*	
2. Claims Payment Details	
Wire Transfer <i>(Please provide the bank account details to which Daman should transfer the money for this reimbursement claim.)</i>	
Beneficiary Name:	
Bank Name:	Branch, Bank Address:
Account Number:	Swift Code Number: (For International Transfers)
IBAN: - - - - -	
I authorise the National Health Insurance Company – Daman PJSC (“Daman”) to make a wire transfer payment against this Reimbursement Claim Form and hereby discharge Daman from any liability with respect of releasing the payment to the bank details as specified by me hereinabove.	
3. Medical Information	
Visit Date:	
Reason for visit/Chief Complaints:	
Diagnosis:	
Treatment Details:	
Currency (If treatment is availed outside UAE):	Total Amount Paid:
4. Checklist – please check that you have included all of the following as required: <i>(Failure to provide the required below documents may result in rejection or delay in the processing of your claim).</i>	
<input type="checkbox"/> Invoices/bills with a breakdown of each medical service and its unit cost. It must show a confirmation of payment or a corresponding receipt.	
<input type="checkbox"/> Complete Medical Report/ discharge summary or a precise identification of the illness (diagnosis) or description of the symptoms by the doctor	
<input type="checkbox"/> Prescription(s) for medications and medical appliances	
5. Terms & Conditions/Authorisation	
<input type="checkbox"/> I agree to the Terms and Conditions herein (refer to the terms and conditions in page 2)	
<input type="checkbox"/> I hereby authorise Mr. /Ms. /Company to receive medical information related to this claim from Daman on my behalf.	
..... Name of Daman member/ Legal Guardian/ Legal Representative Signature
 Date

Terms & Conditions:

I, declare that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition.

I, hereby authorise any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide the National Health Insurance Company - Daman with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalisation or any other information required by Daman.

I hereby declare that the information submitted to Daman is true and correct to the best of my knowledge. I am aware that any person who intentionally makes any false and/or misleading statements to obtain reimbursement from Daman shall be subject to fine and/or imprisonment in accordance with the UAE laws.

I am fully aware that in case I am not satisfied with the settlement of my Reimbursement Amount, I must contact Daman within 180 days from the date of receiving payment notification/rejection letter.

I agree that upon payment of the Reimbursement Amount, I shall transfer the ownership of my original documents to Daman and shall have no future claim against Daman with respect to these documents.

I also undertake that no claims will be made by any person or entity from Daman in future in relation to the aforesaid reimbursement claim. I undertake that in the event of any claim in future by any person to Daman for the Reimbursement Amount, Daman shall have no liability in this regard. I hereby indemnify and hold harmless, Daman and its directors, officers, employees, agents, representatives, assigns and successors from any direct or indirect costs, losses or expenses arising as a result of or in connection with the Reimbursement Amount or my reimbursement claim.

Notice:

We encourage you to **provide all the above required information** and any other **relevant documents** that support your claim, such as travel documents (for international reimbursement claim), diagnostic test and lab test results, etc.

Documents should be provided in **English or Arabic**. We will do our best to accommodate other languages, however you may be asked to provide translated documents by a professional.

All reimbursement claims have to be submitted **within 180 days** from the invoice date.

Please use our [Daman mobile application](#) or [Daman's website](#) to submit your future claims.

If you have any questions or need help completing the claim form, please contact us on:

Customerinfo@damanhealth.ae

600 5 32626 within the UAE or +971 2 6149555 outside UAE.

www.damanhealth.ae