Reimbursement claim form

MEMBERSHIP DETAILS (TO BE COMPLETED BY THE BENEFICIARY)

Company Name : .... Principal Name : ....

Patient Card Number : .... Date of Birth : ....

Amount Claimed : .... Gender : ....

IBAN No : ....

Bank Name : .... Emirates ID : ....

DECLARATION

I hereby appoint the physician or the hospital as my representative to file this medical claim, for injury/sickness. I hereby certify that all answers and documents submitted with the claim form are complete and true, as I am fully aware that any person who intentionally makes any false and/or misleading statement and/or information to obtain reimbursement from INSURANCE HOUSE P.S.C is subject to penalization. I hereby authorize any doctor, hospital clinic or medical provider, any insurance company or any other company, institution or any other person who have any record of information, about me and/or any of my family members to provide INSURANCE HOUSE P.S.C or its authorized representative with the complete information, including copies of their records with reference to any sickness, accident, any treatment, examination, advice or hospitalization.

Patient's Name : .... Relationship to the principal member:...

Signature : .... Date : .... Mobile No : ....

MEDICAL PROVIDER'S SECTION (TO BE COMPLETED BY THE TREATING DOCTOR)

Medical Provider's Name: ....

Chief complaints / symptoms: If the case is chronic Yes ☐ No ☐

....

Diagnosis: ....

Treatment Details: ....

If related to pregnancy/childbirth, the expected/actual delivery date: ....

I declare that I have attended to this patient and the medical services shown in this form are/were medically indicated for his health.

Doctor's Name :.. Stamp / Seal :

Date : .... Signature :