

Reimbursement Claim Form

استمارة التعويض

Tel: +9714 434 2311 Fax: +9714 434 2310, Help Line for 24 Hours: 04 434 2322

Date: / /		Healthcare Provider:		
PATIENT INFORMATION				
Patient's Name (as on card):				<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Card #	<input type="text"/>	Policy No.	<input type="text"/>	Birth date: / /
				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Reason for Not using Almadallah Healthcare Facilities:		<input type="checkbox"/> Emergency <input type="checkbox"/> Family Doctor <input type="checkbox"/> Preferred Personal Choice		
<input type="checkbox"/> Service not available <input type="checkbox"/> On vacation/business trip outside UAE <input type="checkbox"/> Other(s) please specify _____				
INFORMATION				<i>To be completed by Physician</i>
Date of present symptoms:		Symptom(s) as described by Patient:		
	/ /			
	<i>dd mm yy</i>			
Pre-existing Condition(s) being treated for:	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		
Chronic Medications:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes _____		
Family History of any Illness:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify: _____		
OBJECTIVE / ASSESSMENT				<i>To be completed by Physician</i>
Clinical Findings:				
Cause	<input type="checkbox"/> Physical Illness	<input type="checkbox"/> Accident	<input type="checkbox"/> Maternity	<input type="checkbox"/> Preventive
	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Dental	<input type="checkbox"/> Work Related	
<input type="checkbox"/> Other(s), Explain:				
Assessment/Diagnosis	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Suspected
1-				
2-				
MEDICAL PLAN <i>(itemized original invoices & applicable prescriptions/ reports/ results must be enclosed to consider the claim)</i>				
Type of Service	Name & Address of Provider	Service Date	Amount	Bill No.
Currency (if treatment availed outside UAE) _____			Total	
IN-PATIENT <i>(discharge summary, itemized invoices, report, results should be attached)</i>				
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:		