المظلة هيلثكير مانجمنت
ALMADALLAH
HEALTHCARE MANAGEMENT

Dubai National Insurance
دبي الوطنية للتأمين

استمارة التعويض
Reimbursement Claim Form

Please complete all the fields

Tel: +971 4 307 4111, Fax: +971 4 346 4669. Our helpline (24 hours): 80043444 (Toll Free), +971 4 307 4222

Date:	Healthcare Provider:

PATIENT INFORMATION

Patient's Name (as on card):		Mobile Number:	
Card / EID		Birth date: dd / mm / yyyy	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

Reimbursement Claims payment are made to Principal Member's Bank Account by Bank Transfer. Kindly update Principal Member Bank Account details through mobile app or online portal.

يتم سداد مطالبات السداد إلى الحساب المصرفي للعضو الرئيسي عن طريق التحويل المصرفي. يرجى تحديث تفاصيل الحساب المصرفي للعضو الرئيسي من خلال تطبيق الهاتف المحمول أو البوابة الإلكترونية

INFORMATION *To be completed by Physician*

Date of present symptoms: dd / mm / yyyy			Symptom(s) as described by Patient:	
Pre-existing Condition(s) being treated for:	☐ No	☐ Yes	If Yes, Specify:	
Chronic Medications:	☐ No	☐ Yes		
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, reports, 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 **AL MADALLAH** for the purpose of determining insurance benefits.

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