GLOBALNET TPA LLC

Tender Loving Care ...

Claim Reimbursement Form

Please Fill Clearly *(All fields are Mandatory)*

Office Tel.: 04-4474012
(Office Tel. Only on working hours)
Fax: 04-4474013/3697737
Helpline: 056-6102737

Claim Ref. No. *(For GlobalNet Use Only)*

ADMINISTRATIVE

Patient's Name: *		Card No.: *	
Patient's Company: *		Policy No.:	
Employee ID/No. if any:		Patient's Tel. No.: *	
Service Provider:		Nationality:	
DOB: DD / MM / Y YYY *	Sex: ☐M ☐F	Date of Treatment: DD / MM / 20YY *	

MEDICAL SECTION *(By Physician)*

Clinical Findings: Vital Signs: B/P_____T:_____HR:_____RR:_____					
Presenting Complaints/Symptoms:				**Date:** DD / MM /20YY	
				☐ First ☐ Current	
Nature & Cause of Illness: ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Dental ☐ Work Related ☐ Psychiatric ☐ Others					
Diagnosis/Medical Condition: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				**Diagnosis Codes if any**	
1. Diagnosis					
2. Diagnosis					
3. Diagnosis					
Investigations: (Describe procedure):				**Currency**	**Amount**
Cost of medical treatment	**Receipt No's:**		**Total:**		

PRESCRIPTION ADVISED:

Drugs:	**Dose:**	**Duration:**	**Cost:**	**Prescribed By:**	
1.				**Signature & Stamp**	
2.					
3.					
4.				**Date:**	DD / MM /20YY
5.				**Tel. No. if any:**	
6.				**Total:**	**Currency** / **Amount**
Cost of Drugs	**Receipt No's:**				

Cost of medical treatment + Cost of Drugs ***(Must be enclosed medical report, prescription (Discharge summary for IP Cases) and itemized original invoices with complete breakdown to consider claim)***	**Grand Total**	
	Currency	**Amount**
Currency: *(If any treatment done outside UAE)*		

Patient's Declaration		**Employer's Section**	
I Confirm that I am the patient and wish to claim benefit and declare that all the particulars given above are true and correct to the best of my knowledge and I agree that a copy of this consent shall have the validity of the original.		To be attested by HR, Admin Dept./Insurance Coordinator Cheque Payment is to be collected by: (Please tick of any One) ☐ Employer ☐ Employee	
		Name:	
Signature:		**Dept.:**	
	Date: DD / MM /20YY	**Date:** DD / MM / 20YY	**Signature & Stamp**

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INSTRUCTIONS:

Please submit the following Essential documents along with dully filled claim form:

- Original bill/Invoices with date.
- Original prescription for medication given by the treating Doctor.
- Investigation reports like Laboratory test, X-rays, etc.
- Medical report/Discharge summary for Inpatient (Hospitalization cases)
- Copy of passport showing Exit & Re-entry to UAE if treatment done outside UAE.

Claims Submission Period:

Within 30 Days if service taken within UAE (If it exceeds than claim will not be re-imbursed)
Within 60 Days if service taken outside UAE (If it exceeds than claim will not be re-imbursed)

Note:

- Out Patient & In-Patient, Non Network Claims will be reimbursed as mentioned in contract / policy, if the treatment is done in UAE.
- All Claims will be reimbursed as per the contract signed by the insured & insurer.
- Deductible and Co-payment will be deducted from the claimed amount, if any.
- Patient has to bring an approval from the company to collect the cheque, if the cheque is on patient name.
- You need to attach card copy along with the required documents as mentioned above.
- The patient need to present Original card during collection of cheque, if it's on individual name.
- Those treatment and/or drugs which fall on exclusion list "attached with contract" – will not be reimbursed.