MEDCIAL REIMBURSEMENT FORM

Details of Patient:

Name:	**Card No. /UB No.:**
Company Name:	**Service/Claim Type:** ☐ **IP** ☐ **OP**
Policy No.:	**Date of Expiry:**
Pre-Approval Ref. No.:	**Patient Mobile No.:**

Instructions:

- Original Invoices, Discharges Summary, Medical Reports must be enclosed with form.
- Copy of passport showing Exit & Re-Entry to UAE if treatment done outside UAE.

Medical Plan:

Name & Address of Hospital/Clinic/Pharmacy	Bill No.	Treatment Date	Description of Services	Amount (AED)
Currency Name: (if treatment done outside UAE)……			**TOTAL**	

Claims Submission Period: (From the Date of Discharge)

- Within 30 days if service taken within UAE or at Government Hospital.
- Within 40 Days if service taken outside UAE for IP treatment as per the policy terms.

Employer's Section

To be attested by HR Department:	**(Please tick of any One)**
Is the above case work related..?	☐ Yes ☐ No (Pls. Specify): ……
Cheque to be Issued in favor of:	☐ Employer ☐ Employee
Approver Name: …….. Company Stamp & Signature: …….	

Patients Declaration:

I declare, that all particulars given above are to the best of my knowledge true & correct. I agree that a copy of this consent shall have the validity of the original.

Signature: …….. Date: ..... /……. /…….

For Lifeline Use Only:

☐ **Approved** ☐ **Rejected (Reason: ----------)**

Sign & Stamp: …….. **Date: ……**