شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.

Reimbursement Form

Please fill the form Clearly
(All Fields Mandatory)

Medical Provider: AURA ALTERNATIVE MEDICINE CENTRE	**Patient's Name:**		
Date of Treatment: 12/12/25 to 17/12/25	**Patient's Tel:**	**DOB:**	**Sex:** F ☐ M ☐
Emirates ID No:		**Email address:**	

Bank Details:

Name:	**UAE IBAN:**
Bank Name:	

(To be completed by Physician)

Symptom(s) As Described by Patient (MAIN COMPLAINT) Pain in neck & back since 1 month

Date of Present Symptom Onset: 15 / 11 / 2025

What date did the Patient first feel same / similar symptom(s): 15 / 11 / 2025

Is the Patient under any type of treatment / Meds: YES ☐ NO ☐
If yes, indicate what assessment and since when:

OBJECTIVE / ASSESSMENT (*To be completed by Physician*) **Vital Signs T:** 35.8 **P:** **R:** **B/P:** 122/80 mmHg

Past Medical & Surgical History:

Clinical Details & Description of Present Case:

Cause: ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work Related
☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected ☐ Other

Assessment / Diagnosis: *INDICATE DIAGNOSIS NOT SYMPTOM*	**Diagnosis Code**
1. Dorsalgia	M54.9
2. Myalgia	M79.1
3.	

Is Assessment / Diagnosis related to another Assessment? YES ☐ NO ☐

Documents Required:

- **Inside UAE:** 1. Itemized Invoices. 2. Applicable Prescriptions. 3. Receipt/proof of payment 4. Diagnostic investigation Results. 5. Discharge Summary and OT notes (Inpatient).
- **Outside UAE:** same as I in Arabic or English/ translated to English.
- **Physiotherapy:** Referral from Orthopedic or Neurologist
- **Speech Therapy:** Referral from treating doctor

Treating Physician Name: DR SHALINA JAFEER
Name & Address of Facility: AURA ALTERNATIVE MEDICINE CENTRE, SHARJAH
Tel: 065757001
Email:
Signature & Stamp:

DR SHALINA JAFEER ALTERNATIVE MEDICINE PRACTITIONER MOH LICENSE No: T52636

AURA ALTERNATIVE MEDICINE CENTRE P.O.Box: 61688 Sharjah - U.A.E.

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to ABNIC for the purpose of determining insurance benefits.

Patient's Signature (Parent if minor) | *Date* 12/12/2025