

Reimbursement Claim Form

Claim No.	:	INS12345678	Authorization No.	:	PLS12345678
Member Name/ Date of Birth	:	1996-09-25	Membership No	:	INS12345678
Member Address/Tel	:	971508764532	Expiry date of policy	:	2025-03-03

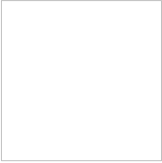
Medical Section

Medical Practitioner's Name and Address/Tel.	Medical condition:
Amirtha Patel	xcv

declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Please Give the date on which your patient first consulted any doctor for this condition
2024-05-02

Signature & Stamp



Date
2024-05-02

History of medical condition:

Details of Physical findings

Details of any investigations done with relevant dates.

Details of treatments done with relevant dates.

Total Amount

345.0000

Patient's Declaration and Consent

Signature :

Date : 2024-05-02

I confirm that I am the patient/ patient's parent or guardian and wish to claim benefits, and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to DubaiCare. I agree that a copy of this consent shall have the validity of the original.

Please send this form to DubaiCare, P.O. Box 3027 Dubai âC" UAE Toll Free: 800 3 82467 (Including original invoice with paid stamp, investigation and prescription) For any enquiry please call from 08.00 am to 17.00 pm (Sunday to Thursday)