Reimbursement Claim Form

Claim No.	:	1234	Authorization No.	:	122
Member Name/ Date of Birth	:	1996-06-20	Membership No	:	1234
Member Address/Tel	:	971506245967	Expiry date of policy	:	2023-12-20

Medical Section

Medical Practitioner's Name and Address/Tel. Amirtha Patel	Medical condition: sdf
declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct. Signature & Stamp Date 2024-04-27	Please Give the date on which your patient first consulted any doctor for this condition 3434.0000
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 3434.0000	
Patient's Declaration and Consent	Medical condition: Signature
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.	Date : 2024-04-27

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Patient's Signature
2024-04-27

Date

Pharmaceuticals (to be filled by treating doctor only)