REIMBURSEMENT MEDICAL CLAIM FORM

Please read the instructions & guidelines on overleaf before filling the form 1. Patient Details Patient's Name: Broup Member's Name: Bemail ID: 2. Reason for not using listed helathcare facilities (Kindly indicate) Dther (s) please specify 3. Medical Information (7 to be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required) Condition Requiring treatment brough Designation of illness: grig Treatment Details EXEXYAXICK Reduced that I have attended to this patient and that the particulars given are best of my knowledge true and correct. Stamp: Date: 2023-11- 27 4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Potails CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency (If treatment availed outside UAE)								
L. Patient Details Patient's Name: Ranging Member's Name: Employer's Name: Itent Type of Plan: Address: Doctor Vision Telephone No: 971563568775 Date 2023 Of 2023 Of 371563568775 Date 2023 Of 37156356875 Date 2023 Of 3715636875 Date 2023 Of 37156875 Date 2023 Of 3715687								Voucher No :44
L. Patient Details Patient's Name: Ranging Member's Name: Employer's Name: Itent Type of Plan: Address: Doctor Vision Telephone No: 971563568775 Date 2023 Of 2023 Of 371563568775 Date 2023 Of 37156356875 Date 2023 Of 3715636875 Date 2023 Of 37156875 Date 2023 Of 3715687								
Patient's Name: Count Member's Name: Count Name: Co		Please read the	instructions 8	k guideline	s on overleaf befo	re filling the form		
Patient's Name: Count Member's Name: Count Name: Co						-		
And the state of the Hospital / Clinic Treatment Details CPT Code Treatment Details CPT Code Treatment availed outside UAE) Stank Details CPT Code Treatment availed outside UAE) Stank Details Bank Details Bank Details Card No: P15/63/31/31/31/31/31/31/31/31/31/31/31/31/31	1. Patient Details							
Group Member's Name: Imployer's Name: Im	Patient's Name:				test test		PLS765432	21
Email ID: Address: Address: Date 2023 6 Birth: 10-2 Dither(s) please specify 3. Medical Information(To be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required) Condition Requiring treatmentbrough Condition Requiring treatmentbrough Conset and duration of illness: gifg Treatment Details EXEXZENCE (addedare that i have attended to this patient and that the particulars given are best of my knowledge true and correct. Name & Signature of the Doctor: Treatment Details CPT Code Treatment Details CPT Code Treatment availed outside UAE) Stank Details Bank Details Bank Details Bank Address:	Group Member's Name:							
2. Reason for not using listed helathcare facilities (Kindly indicate) Dither(s) please specify 3. Medical Information(To be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required) Condition Requiring treatmentbrogb Unisit Date28- 11-2023 00:00:00 Disect and duration of illness: 1969 17eratment Details EXEMPTION A. Name & Address of the Hospital/Clinic Treatment Details Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5.8ank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:	Employer's Name:				Doctor Vision	Telephone No:	97156356	Date
2. Reason for not using listed helathcare facilities (Kindly indicate) 2. Medical Information (To be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required) 2. Medical Information (To be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required) 2. Misit Date 28-11-2023	Email ID:					Address:		of 2021
Condition Requiring treatmentb frog b Onset and duration of illness: Interpretation	for cases like hospitalization procedures surgeries-detailed medical							birtn:
Onset and duration of illness: (grig Treatment Details XXXXXXXX (I declare that i have attended to this patient and that the particulars given are best of my knowledge true and correct. Name & Signature of the Doctor: Stamp: Date:2023-11- 27 4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:								
Treatment Details EXAMPLE ANAME & Address: CPT Code Treatment Details CUTTENT COMPANIES COURTERCY (If treatment availed outside UAE) Sank Details Bank Details Bank Address:	Condition Requiring treatmentbfcvgb					-		
Name & Signature of the Doctor: Date: 2023-11- 27 4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:	fgfg Treatment Details ZXXZXCXC I declare that i have a	attended to this patient		articulars				
4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5. Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:		_	rect.		Stamp	:		
4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5. Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:								
4. Name & Address of the Hospital/Clinic Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5. Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:								
Treatment Details CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:					27			
CPT Code Treatment Type Price Auth. Code Auth. Date Exp. Date Currency(If treatment availed outside UAE) 5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name:	4. Name & Address of the Hospital/Clinic					Treatment Details		
Currency(If treatment availed outside UAE) 5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:	Treatment Details							
5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:	CPT Code	Treatment	Туре	Price	Auth. Code	Auth.	Date	Exp. Date
5.Bank Details Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:								
Bank Details(Compulsory): Account Holder Name: Bank Name: Bank Address:	Currency(If treatr	nent availed outsio	de UAE)					
Account Holder Name: Bank Name: Bank Address:	5.Bank Details							
Bank Name: Bank Address:	Bank Details(Comp	ulsory):						
Bank Address:	Account Holder Nam	ne:						
	Bank Name:							
Currency: SWIFT Code:	Bank Address:							
	Currency:					SWIFT Code:		

6.Other Information

Is the above case work related

Is the claim covered by another insurance

7.Declaration

I, the undersigned hereby declared that the information above is true and complete and that reimbursement requested is for expense paid by me for the treatment of my medical condition.

I agree to submit to ADNIC any requested document mandatory / deemed necessary to process my above claim . I hereby authorize ADNIC to approach ,and any doctor / Medical facility/ any Institution or any person who has any record / medical information about me or my family member to provide ADNIC with complete information including copies of the records when requested.

CXV

2023-11-27

CXC

Name Relationship to the Card Holder

Signature

Date

Contact No.

Instructions

- 1. This form needs to be completed by the insured member (Card holder), only if the provider is not submitting the claim on his behalf.
- 2.Please read the form carefully and make sure to complete all pertinent information. ADNIC will not be able to process any incomplete Reimbursement Claim Form with lacking proper documentation.
- 3.Use a separate form for each Member.
- 4.All the documents including invoices and medical reports should be in either English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
- 5. The following documents to be attached to your duly filled Reimbursement Claim Form.
 - • Copy of Card.
 - • Original itemized bill/Invoices (dated) and receipts of payment.
 - Original prescription for medication given by the treating doctor (except for controlled drugs).
 Validity of the prescription is limited to 60 days and for controlled drugs is limited to 3 days in line with HAAD
 - • Investigation requests/reports like laboratory tests, x-rays, etc.

Additional requirements to above:

For Inpatient (Hospitalization Cases)

• Medical Report/Discharge Summary stamped & signed by the treating Doctor.

For treatment availed Outside the UAE

- • Copy of passport showing Exit & Re-entry to UAE or any other similar documents (E.g.: E-gate)
- • Elective treatment is subject to ADNIC prior approval at all times.
 - 6.Please retain copies of receipts and documents enclosed with your claim, as ADNIC will retain original documents.
 - 7.All claims s ubject to reimbursement availed within or outside UAE should be submitted within 120 days of incurred treatment.
 - 8. Please submit all the above required documents directly to MSH international DIFC Liberty House Office No 304, Level 3, P.O Box 506537, Dubai, United Arab Emirates

If you need assistance in filling this form please call MSH Toll Free (UAE): $800674823|+971\ 4365\ 1350$

Instructions to complete the Form

- 1. Please write your name & Card Number as mentioned in the Card
- 2.Medical Information $\hat{a} \in \mathbb{N}$ Request your treating doctor to fill up brief medical information about your condition and treatment.
- 3.Provider Name & Address $\hat{a} \in \mathbb{N}$ Kindly use more than one line if necessary to provide this information about each facility where you were treated
- 4.Bill No. $\hat{a} \in \mathbb{N}$ Please write the serial number/reference number printed on the bill/receipt/invoice for each service separately.
- 5.Service Date â€" State date of treatment for each service against each bill.
- 6.Description of Services $\hat{a}\in State$ type of service like Consultation/Pharmacy/Investigations/Physiotherapy/Dental/ Hospitalization.
- 7.Amount â€" State the exact amount as appears on the invoices
- 8.Total $\hat{a} \in \mathbb{N}$ Total amount of all the invoices submitted with this form for reimbursement from ADNIC
- 9.Currency â€" Name of the currency in which actual payment was made.
- 10.If treatment due to road traffic accident a police report is required to be submitted with this form.
- 11.Declaration $\hat{a} \in \mathbb{N}$ Kindly write your name, signature, date, the contact number and relationship to the cardholder.