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.

Amirtha Patel

Medical condition:

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.

Signature & Stamp

Date

2024-05-02

Please Give the date on which your patient first consulted any doctor for this condition

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

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.

Signature :

Date : 2024-05-02

Please send this form to DubaiCare, P.O. Box 3027 Dubai â€“ 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)