REIMBURSEMENT MEDICAL CLAIM FORM

Voucher No :44

Please read the instructions & guidelines on overleaf before filling the form

1. Patient Details

Patient's Name:	test test	**Patient Health Card No:**	PLS7654321
Group Member's Name:	rtert	**Type of Plan:**	ADNIC
Employer's Name:	Doctor Vision	**Telephone No:**	971563568775
Email ID:		**Address:**	**Date of Birth:** 2021-10-20

2. Reason for not using listed helathcare facilities(Kindly indicate)

Other(s) please specify fdgfdg

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 treatmentbfcvgb

Visit Date28-11-2023 00:00:00

Onset and duration of illness:
fgfg

Treatment Details
zxxzxcxc

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**
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:	
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.

- â€¢ Copy of Card.
- â€¢ Original itemized bill/Invoices (dated) and receipts of payment.
- â€¢ 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
- â€¢ Investigation requests/reports like laboratory tests, x-rays, etc.

Additional requirements to above:

For Inpatient (Hospitalization Cases)

â€¢ Medical Report/Discharge Summary stamped & signed by the treating Doctor.

For treatment availed Outside the UAE

- â€¢ Copy of passport showing Exit & Re-entry to UAE or any other similar documents (E.g.: E-gate)
- â€¢ 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 4 365 1350

Instructions to complete the Form

1.Please write your name & Card Number as mentioned in the Card

2.Medical Information â€" Request your treating doctor to fill up brief medical information about your condition and treatment.

3.Provider Name & Address â€" Kindly use more than one line if necessary to provide this information about each facility where you were treated

4.Bill No. â€" 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 â€"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 â€" 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 â€" Kindly write your name, signature, date, the contact number and relationship to the cardholder.