AL-BUHAIRA NATIONAL INSURANCE COMPANY
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

MEDICAL EXPENSES CLAIM FORM

To be completed by Medical Attendant in full.

1. Patient's Name : .....Date of birth [as on ID card]: ……

2. ACCIDENT / SICKNESS : New Visit : _____ Follow up : _____
(Please Specify if accident, is it work related?) (Tick where applicable)

(a) Present complains :.... .... Duration : ……

(b) Its origin and cause: ……

3. Has the claimant previously suffered from the above trouble? :…… ……

YES _____ NO _____

If the answer is "YES" state :

a) Its nature ……..……

b) The period/s involved ……..…

4. Has the claimant previouslly suffered from any other accident or illness which affects the present disablement ?

YES …….. NO……...

If the answer is "YES" state :

a) Its nature ……..…….

b) The period/s involved……

5. If any of the following is required, please specify type of test and indication

	Laboratory ☐	Radiology ☐	Procedure ☐
Type			
Indication			

6. Treatment provided : Medicine _____ Injection _____ Procedures _____ others _____
(Please tick as applicable) -

7. **Diagnosis :**
……..

8. I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification :_____Signature : _____ Date : _____

9. DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records with reference to any sickness or accident , any treatment , examination , advice or hospitalization . Any photocopy of this authorization shall be taken as original copy .

Policy Holder : ……..……..…….

Patient's Name ……. ……..……. Insurance I.D No.…….……..

Signature …….. Date ……...…….……..……

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month.