ADNIC

شـــركـة أبـوظـبي الوطـنـية للتأمين

ABU DHABI NATIONAL INSURANCE COMPANY

INCORPORATED IN ABU DHABI IN 1972 – PAID UP CAPITAL DHS. 375,000,000, SUBJECT TO THE PROVISIONS OF FEDERAL LAW No. (9) OF 1984 REGISTRATION NO. (1) DATED 22-07-1984

# REIMBURSEMENT MEDICAL CLAIM FORM

**Voucher No.:**

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

1. **Patient's Name:** 2. **Patient's Health Card No.:**

3. **Group Member's Name**

4. **Reason for not using listed Healthcare facilities** (kindly indicate)

☐ Emergency ☐ Elective ☐ Service not available ☐ On vacation/business trip outside UAE

☐ Other(s) please specify.....

5. **Medical information** (To be filled by treating Doctor for all outpatient treatment. For cases like hospitalization procedures surgeries-detailed Medical report is required)

**Condition requiring treatment:** **Visit Date:**

**Treatment Details:**

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:** ..... **Date:** ..... **Stamp:**

| 6. Name & Address of the Hospital/Clinic | Bill No. | Treatment Date | Description of Services | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Currency** (if treatment availed outside UAE) ..... **TOTAL**

7. **Other Information**

**Is the above case work related?** ☐ **No** ☐ **Yes** (full details) .....

**Is the claim covered by another Insurance** ☐ **No** ☐ **Yes** (Pls specify the amount reimbursed and by which Insurance Company)

8. **Declaration**

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

..... ..... ..... .....

**Name** **Signature** **Date** **Contact No.**

**Relationship to the Card Holder**

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## 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 medicines)*
   - *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)*
   - *Letter from your employer stating reason for travel i.e. for vacation or business trip.*
   - *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 subject to reimbursement should be submitted to ADNIC:**
   a) Within 45 days if service taken within UAE and outside the network.
   b) Within 60 days if service taken outside UAE and outside the network.

8. Please submit all the above required documents directly to:

   **ABU DHABI NATIONAL INSURANCE COMPANY**
   **P.O. BOX : 839, ABU DHABI**
   **U.A.E.**

   If you need assistance in filling this form please call **8008040**

## Instructions to complete the Form

1. **Please write your name & Card Number** *as mentioned in the Card.*
2. **Medical Information –** *Request your treating doctor to fill up brief medical information about your condition and treatment.*
3. **Provider Name & Address** – *Kindly use more than one line if necessary to provide this information about each facility where you were treated.*
4. **Bill No.** – *Please write the serial number/reference number printed on the bill/receipt/invoice for each service separately.*
5. **Service Date** – *State date of treatment for each service against each bill.*
6. **Description of Services** –*State type of service like Consultation/Pharmacy/Investigations/Physiotherapy/Dental/ Hospitalization.*
7. **Amount –** *State the exact amount as appears on the invoices.*
8. **Total –** *Total amount of all the invoices submitted with this form for reimbursement from ADNIC.*
9. **Currency –** *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 –** *Kindly write your name, signature, date, the contact number and relationship to the cardholder.*