دار التأمين
INSURANCE HOUSE
P.S.C - ش.م.ع

REIMBURSEMENT CLAIM FORM

MEMBERSHIP DETAILS (TO BE COMPLETED BY THE BENEFICIARY)

Company Name : _____ Principle Name : .....

Card Number : ..... Patient's Name : .....

Amount Claimed : ..... Date of Birth / Sex : .....

Date : ..... Contact No. : .....

DECLARATION

I hereby appoint the physician or the hospital as my representative to file this medical claim, for injury/sickness. I hereby certify that all answers and documents submitted with the claim form are complete and true, as I am fully aware that any person who intentionally makes any false and/or misleading statement and/or information to obtain reimbursement from INSURANCE HOUSE P.S.C is subject to penalization. I hereby authorize any doctor, hospital clinic or medical provider, any insurance company or any other company, institution or any other person who have any record of information, about me and/or any of my family members to provide INSURANCE HOUSE P.S.C or its authorized representative with the complete information, including copies of their records with reference to any sickness, accident, any treatment, examination, advice or hospitalization.

Patient's Name : ..... Relationship to the cardholder : .....

Signature : ..... Date : .....

MEDICAL PROVIDER'S SECTION (TO BE COMPLETED BY THE TREATING DOCTOR)

Medical Provider's Name: .....

Chief complaints / symptoms: If the case is chronic Yes ☐ No ☐

.....

Diagnosis: .....

Treatment Details: .....

If related to pregnancy/childbirth, the expected/actual delivery date: .....

I declare that I have attended to this patient and the medical services shown in this form are/were medically indicated for his health.

Doctor's Name & Signature: ..... Stamp / Seal: .....

Date: .....

REIMBURSEMENT CLAIM FORM

BENEFICIARY REQUIREMENTS
(ALL DOCUMENTS SHOULD BE DULY FILLED & SUBMITTED WITH THE REIMBURSEMENT CLAIM FORM)

- Copy of INSURANCE HOUSE P.S.C card.
- Original diagnostic reports stamped and signed by the treating doctor.
- Original itemized bill/invoices with date.
- Original prescription for medication given by the doctor.
- Investigation results/reports like laboratory test, x-rays, MRI, etc.
- For inpatient (Hospitalization Cases), you copy of the passport showing Exit & Re-entry to UAE or any other similar documents.
- For treatment availed outside the UAE, copy of the passport showing Exit & Re-entry to UAE or any other similar documents.
- All the documents including invoices and medical reports should be either English or Arabic. Documents in other languages must be translated by an official public translation prior to submission.
- Use separate form for each INSURANCE HOUSE P.S.C member.

Please retain copies of receipts and documents enclosed with your claim, as INSURANCE HOUSE P.S.C will not return the original documents.

Note: Reimbursement claims must be submitted through HR Department within 15 days from the treatment date in UAE and 30 days for treatment outside UAE.

دار التأمين
INSURANCE HOUSE
P.S.C - ش.م.ع

REIMBURSEMENT CLAIM FORM

FOR THE USE OF INSURANCE HOUSE P.S.C ONLY

P.O. Box 129921, Abu Dhabi, United Arab Emirates – Tel (+971) 2 4934444 – Fax: (+971) 2 4934400.