Please Use **BLOCK** letters to fill this form.
Please ensure that all sections are fully completed and attach all original receipt(s) showing the diagnosis and a full breakdown of cost for each condition being claimed.

Section 1 Member/Patient Information

Principal Insured Name	
Insurance Card Number of the patient	
Patient's name and address	
Patient's Date of birth	
Employee No/ Staff ID: (If applicable)	
Employer's Name (If applicable)	
Principal Insured's Tel number (mobile)	
Principal Insured's Email address	
Nationality	

Section 2 Medical Information

(To be fully completed by patient's medical practitioner – all boxes must be completed in BLOCK letters.)

Country of Treatment	
Provider's name Physician's Name	Physician's /telephone/ fax/ email
Physician's address	Date of first symptoms noticed
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Physician's signature and stamp Date / /

Please retain a copy for your records

Diagnosis (Please provide precise diagnosis or symptom (s) and details of any test (s) conducted)

Primary:

Secondary:

Section 3 Financial Section (to be completed by the Principal Insured/Guardian)

Outpatient Treatment	Claimed Amount and Currency	Inpatient Treatment **	Claimed Amount and Currency
Consultation		Hospital charges/ Room	
Pharmacy		Surgery/Anesthesia/OT	
Diagnostic/Lab/Others		Drugs/Labs/Others	
Total Claimed Amount and Claimed Currency			

Section 4 Patient's Declaration and Consent

I confirm I am the patient/patient's spouse or guardian (if patient is under 18 years of age) and wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I, the undersigned, authorize and request any hospital, physician, and any other health provider to furnish NAS Administration services with the complete information including copies of their records in connection with medical treatment or other services provided to me or to my dependent.

I agree that a copy of this consent shall have the validity of the original

Signature of the Patient/Patient's Spouse /Guardian

Date / / 20

Section 5 Documents' Submission (IMPORTANT)

Please submit the following documents:

a. Original invoices and receipts with itemized breakdown
b. Original medical report from your treating physician
c. Original or copies of report/result of investigations carried out
d. Complete Reimbursement Claim Form

*NOTE: We reserve the right to request for the original receipts or further documentation if deemed necessary to finalize the claim evaluation and processing.

**NOTE: NAS pre-approval is required for all In-patient treatment. Before admission/surgery, you are required to send to NAS a detailed medical report and cost estimate of the proposed surgical procedure/treatment on the letterhead of the hospital with affixed physician's stamp and signature along with the result of relevant investigations carried out and e-mail it to claimscenter@nas.ae. Thereafter, you shall receive a reply from NAS regarding reimbursement coverage.

Please retain a copy for your records

All Documents must be submitted in English or Arabic, documents in other languages must be translated prior to submission.

Please retain a copy for your records