

Important information:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).

If the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is less than USD 500 **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to MEAService@now-health.com or fax it to +971 (0) 4450 1430. Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/discharge reports and email them to MEAService@now-health.com or fax them to +971 (0)4450 1410. Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

If **You** have any questions about this form or any other aspect of your cover, please call us on +971 (0) 4450 1410 or email us at MEAService@now-health.com.

Section 1: Member and Patient Information:

Planholder's name:	Plan number:
Patient's name:	Membership number:
Date of birth (dd/mm/yyyy): / /	
Claim settlement address:	
Email address:	Telephone number:
Reason for doctor visit/diagnosis:	
Country where Treatment took place:	Treatment date (dd/mm/yyyy): / /
Currency claim incurred in:	Currency You would like Your claim reimbursed in:
Total claimed amount:	Type of service: Out-Patient <input type="checkbox"/> Day-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/>
Attending physician: Dentist <input type="checkbox"/> Medical Practitioner <input type="checkbox"/> Specialist <input type="checkbox"/> Other <input type="checkbox"/> Please specify:	
Is this claim due to Accident /injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, include complete medical information. Date of Accident /injury (dd/mm/yyyy): / /	

Third party insurers

If some of the costs are recoverable from a third party (for example, a person or organisation involved in an **Accident**), please provide details:

Section 2: Payment details – please ensure all sections are completed

Please pay: Planholder <input type="checkbox"/> Provider <input type="checkbox"/>		
Please choose payment type: Bank transfer <input type="checkbox"/> Foreign draft <input type="checkbox"/> Cheque <input type="checkbox"/>		
1. Bank transfer – please complete all details to enable bank transfer payments.*		
Account/payee name:	Payment currency:	
Bank name:	Bank address:	
Email address:		
IBAN or account no.:	Routing code (e.g. Swift or sort code):	
2. Foreign draft – please specify currency:	Payee name:	Banking country:
3. Cheque: Payee name		
Claim settlement address:		

* Please check with **Your** local bank as there may be a charge for this service.

I have read the declaration in Section 4 on the next page

I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.

Patient's signature (Insured/main applicant):

Date (dd/mm/yyyy):

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Section 3: Medical information, claims over USD 500

(to be completed by the doctor responsible for the patient's **Treatment**)

Medical Condition:	Diagnosis ICD10 code:
Details of any underlying cause:	
When did the patient first see a doctor? (dd/mm/yyyy) / /	
Details of Treatment /medication:	
Details of operation (if any):	
	Procedure code:
Hospital details (if applicable):	Treatment date (dd/mm/yyyy): / /
Name:	
Address:	
Admission date (dd/mm/yyyy): / /	
Discharge date (dd/mm/yyyy): / /	

Medical Practitioner Declaration:

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.

Print name:	Official stamp:
Signature:	
Date (dd/mm/yyyy): / /	

If **Your Plan** includes a cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.
Direct Billing: It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on +971 (0) 4450 1410.

Section 4: Declaration

We may contact **You** with details of other products and services which may be of interest to **You**. **You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box .

Declaration

I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International (Services) FZ LLC, Ground floor, Al Shaiba building, Dubai Outsource Zone, P.O Box 502163, Dubai, UAE.