MEMBER REIMBURSEMENT CLAIM FORM

Amity Health

P.O. Box: 118833, Dubai, United Arab Emirates , Toll free: 800-2432584 www.amity.ae

SECTION A: MEDICAL PROVIDER AND PATIENT DETAILS

Provider Name:		**Provider License No :**	
Patient Name :		**Patient email ID:**	
Company Name:		**Patient Mobile No:**	
Card Number:		**Patient File No :**	

Patient DOB: ___/___/____ (dd mm yyyy)

SECTION C : CLAIM DETAILS

To be completed by Attending Physician (please tick √) ☐ Inpatient ☐ Outpatient Emergency case?(please tick √) ☐ Yes ☐ No

Chief Complaint and symptoms:	What date did the patient first feel same/similar symptoms ___/___/_____ (dd mm yyyy)
Significant signs:	Pre Authorisation No: (If Applicable)
Other conditions:	Date of this Visit: ___/___/_____ (dd mm yyyy)

Diagnosis:

Mandatory: ICD code(please tick √) ☐ ICD9 ☐ ICD10

Principal code: _____ 2nd code: _____ 3rd code: _____ 4th code: _____

Please tick (√) where appropriate

☐ Congenital ☐ Chronic ☐ RTA ☐ Psychiatric ☐ Others(please specify)_____

☐ Check-up ☐ Acute ☐ Infertility ☐ Work related ☐ Vaccination ☐ Pregnancy/Indicate LMP: _____

SECTION D: PROPOSED MEDICAL MANAGEMENT PLAN

Suggestive line(s) of management: kindly, enumerate the recommended investigations and / or procedures

Code	Type of Code Used	Description /Service	Quantity	Type	Cost
				Total cost	

Anticipated management plan:

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Referral Doctors Name: (If Patient has been Referred) _____ Licence No: _____

Patient declaration

I declare that I am the patient, patient's parent or guardian (if patient's under 16 years of age) and that all information provided in the claim form is to the best of my knowledge true and correct. This declaration gives Amity the permission to get all information about my claim including, but not limited to, my current medical and previous medical providers/physician, pharmacy or any other person who has provided medical services to me or my dependants. I agree that a copy of this consent shall have the validity of the original.

Signature : _____ Date: ___/___/_____ (dd mm yyyy)

Medical practitioner declaration

I declare that all information mentioned is correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Name : _____ Tel/fax : _____ Signature and stamp: _____

Date: ___/___/_____ (dd mm yyyy) License No: _____

RAK INSURANCE

RAK Insurance Medical Reimbursement Claim Form & Checklist

Policy Details	
Name of the Insured/Employer*	
Name of the Employee*	
Card No.*	
Contact No. Mobile*	

Details of Patient	
Name of the Patient*	
Age of the Patient*	
Date of Treatment*	
If hospitalized, Date of Admission	
If hospitalized, Date of Discharge	

Claim Quantum *(Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim)*

Service Description	*Amount (AED)*	*Amount foreign currency*
Consultation Fees		
Diagnostic & LabortoryTests		
Physiotherapy		
Pharmacy		
Inpatient Bill		
Alternative Treatment / Medicines		
Miscellanoeus / other costs		
Total:		

Checklist	Yes
1. Consultation Invoice.	
1.a. Consultation with breakdown if any other treatment is included with it.	
2. Laboratory/Radiology Invoice.	
2.a. Itemized breakdown of cost of laboratory tests.	
2.b. Laboratory/Radiology reports.	
3. Pharmacy Invoice.	
3.a. Itemized breakdown of cost of pharmacy items.	
3.b. Prescription from treating doctor for each invoice.	
4. Dental Treatment.	
4.a. Itemized breakdown of cost of consultation and dental treatment.	
4.b. Dental treatment summary (inclusive of tooth number).	
5. Optical Treatment.	
5.a. Itemized breakdown of cost of consultation, Lens and Frames.	
5.b. Optical prescription.	
6. Maternity.	
6.a. Itemized breakdown of cost of consultation, lab tests, radiology tests, and inpatient services rendered.	
6.b. Investigations reports.	
6.c. Detailed Discharge summary from hospital admission to discharge of mother.	
6.d. Detailed Discharge summary from hospital admission to discharge of baby.	
7. For Inpatient (Hospitalization Cases).	
7.a. Medical discharge report/summary stamped & signed by the treating doctor.	
7.b. Signed & dated Original itemized bill/invoice.	
7.c. Original prescription for medication by the treating doctor.	
7.d. Investigation results/reports. Like diagnosis, laboratory tests, x-rays, etc.	
8. If claim incurred outside UAE – English/Arabic translated documents are provided.	
9. Separate claim forms and invoices (as specified above) is submitted for each claimant.	
10. Is the claim within the specified cut off period as per the policy*?	

Note:

~ Original invoices should be provided for Reimbursement.

~ *Within the UAE reimbursement claims should be reported to RAK Insurance within 60 days from the date of occurrence, and for outside of the UAE within 90 days from the date of occurrence.

~ Please note that RAK Insurance requires a minimum set of information in order to be able to process your reimbursement claim. Properly documented claims will result in speeding up the claim's settlement time.

Employer / Employee Declaration

I hereby declare that to the best of my knowledge and belief, the statements and answers in this form are true and correct in

Name of the Employer / Employee *(Parent if minor)* :

Signature of the Employer / Employee *(Parent if minor)* :	Signature here	Date