RAKinsurance
شركة رأس الخيمة الوطنية للتأمين (ش.م.ع)
RAS AL-KHAIMAH NATIONAL INSURANCE CO. (P.S.C.)

# Reimbursement Claim Form

NAS

If you have any questions regarding this form or any other aspects of your insurance cover, please call ***NAS*** **+971 2 6940800** or Toll Free **800 2311**

## DETAILS OF MEMBER/PATIENT

*** MARKED ARE MANDATORY**

| | |
|---|---|
| Patient's name* | Patient's Card No * |
| Date of Birth* | Employee's/patient's Telephone no and email id* |

## PATIENT SECTION

| Name and Address of the hospital/clinic/provider* | Bill/Invoice no | Service date* | Type of services availed * | Amount* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Currency | | | Total* | |

## MEDICAL SECTION* (To be fully completed by patient's medical practitioner)*

**Date symptoms first noticed ***

**Diagnosis ***

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 name and address with signature and stamp**

Date / /

## PATIENT DECLARATION AND CONSENT *

I confirm I am the patient/patient's spouse or guardian (if patient under 16 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. I hereby consent to and authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to RAKNIC/NAS. I agree that a copy of this consent shall have the validity of the original.

Signature Date / /

****Reimbursement claim must be submitted within 60 days if the treatment is done from U.A.E and within 90 days if the treatment is done outside U.A.E****