NEXtCARE
Your Health Managed with Care

REMIBURSEMENT ASOAP FORM

24 hour Tel: 011-0008103 , Fax: 02-22908220 –Office Number during Business Hours:02-24182564

Please complete Clearly (All Fields Mandatory) **Form No.**

ADMINISTRATIVE

Healthcare Provider: مقدم الخدمة	**Patient's Name:** اسم المريض		
Date Of Service: ___/____/_____ التاريخ dd mm yyyy	**Patient's Tel:** تليفون المريض	**DOB:** ___/____/____ تاريخ الميلاد dd mm yyyy	**Sex:** ☐F ☐M ذكر انثى
Card No. *(Mandatory)* رقم بطاقة التأمين الطبي			**Patient's Employer:** *(Mandatory)* جهة العمل

SUBJECTIVE (*To be completed by physician)*

Symptom(s) As described by Patient(Chief Complaint) الاعراض

Date of Present Symptom Onset: ___/____/_____ تاريخ بداية العرض dd mm yyyy

What date did the Patient first feel same/similar Symptom(s): ___/____/_____ تاريخ اول مرة شعر فيها المريض بالاعراض من قبل dd mm yyyy

Is the Patient under any type of treatment? ☐ **yes** ☐**No** *If Yes, indicate what Assessment and since when:* هل يتلقى المريض أى علاج إذا نعم ما نوع العلاج ومنذ متى

OBJECTIVE/ASSESSMENT (*To be completed by Physician*) الفحص السريرى، التشخيص والعلاج

Clinical Finding : **Vital Signs:** ☐**B/P:**_____ ☐**T:**____ ☐ **IIR:**____ ☐**RR:**_____

Cause* :☐ Physical ☐ Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐*Work Related* ☐*Other

Assessment/Diagnosis: ☐Acute ☐ Chronic ☐Confirmed ☐Suspected	***Diagnosis Code***
1-	
2-	
3-	

Is Assessment/Diagnosis related to anther Assessment? ☐ yes ☐No *If yes, specify (I.e. Retinopathy related to Diabetes)*

Medical PLAN *Itemized Original Invoice and Applicable Prescription/ Reports must be enclosed to consider claim.*

☐ **Consultation**	**Cost**	☐ **Physiotherapy**	**Cost**
☐ **Pharmacy**	**Cost**	☐ **Laboratory**	**Cost**
TOTAL CHARGES			

Was In –patient Required? Length of Stay_____ Indicate Provider _____Cost_____

Discharge Summary, Itemized Invoice, Reports & Receipts Attached?

Treating Physician Name :_____
Tel/Fax:_____
Signature &Stamp:_____

I hereby authorize any Healthcare provider, Insurance, Employer or other Organization to release any information regarding my medical condition &history to NEXtCARE for the purpose of determining insurance benefits.

Patient Signature(Parent if minor) ***Date***

الإتحاد للتأمين
UNIONINSURANCE

CHECK LIST FOR SUBMISSION OF REIMBURSEMENT CLAIM

Very IMP:

- ***All Documents submission must be in Arabic or English.***
- ***Do not forget to attach this checklist with the Claim file.***
- ***Arrange the documents in the same order as in the checklist, checking against the designated Box when you do so. This way you can ensure that you have not missed any documents.***

Employee Name: - _____**Health Card No:** _____

Name of the Company: _____ **Contact No**: _____

Cheque to be drawn to: _____

Check list for Documents: Please put a "X" mark against the box

1. **Original Claim Form duly filled with final diagnosis and signed by Claimant and the treating doctor.** ☐

2. **Original Hospital bill with Bill Number & break up**, ☐
(With detailed break up of various service heads like Room Rent/OT charges/Nursing/Surgical & non-Surgical Supplies etc).

3. **Original Hospital Payment Receipt with receipt number.** ☐
(When payment is done through credit cards, please attached the payment Credit Card slip/ Receipt, all cash invoice must have clear stamp as PAID)

4. **Discharge summary, Procedure Notes** ☐
(Gives the summary of diagnosis, treatment in hospital with date of admission and discharge, For Implants used in Cataract, Heart Valve surgeries, CABG, Abdominal Surgeries, Knee replacement Surgeries, please submit the prosthetic device used along with Sticker)

5. **Pharmacy and Investigation bills** ☐
(Along with prescriptions, Radiology & Lab results reports).

6. **Original prescriptions** ☐
(On doctor's letterhead mentioning duration and dosage for medicines and advice for diagnostic tests).

7. **Investigation reports in original/attested from hospital** ☐
(Reports for all tests done along with images)

8. **Police Reports for all RTA Claims** ☐
(Mandatory for All Road traffic accidents-Duly attested by Treatment undergone Country Police)

9. **Original Death summary** ☐
(Only in case of death of Patient during Hospital stay).

Points to remember:

- Please retain copies of all the documents submitted to us for future reference.
- For any assistance with any of the above formats, please contact us at medclaims@unioninsurance.ae or call at 04 - 3787713
- Please retain a POD copy of the courier for tracking your consignment in case of any delay etc.
- The above list of documents is indicative. In case of any other document requirement as specified by the Insurance company our Document recovery Team will contact you on receipt of your claim documents by us.