Claim Reimbursement Form

Card Holder's Name: _____ Card No.: _____

Valid Until: _____ Contact Telephone: _____

To be completed by the treating Physician

Dear Doctor: The beneficiary participating in our Program is consulting you for medical care and kindly requests you to complete this form.

Diagnosis : _____

_____

Date of onset of symptoms :_____

If, hospitalized : Date of
Admission _____ Discharge _____

Case Management :_____

_____

Actual Costs :_____
(Attach all original receipts)

Treatment Plan

Diagnostic Tests	**Pharmaceuticals**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Date Cardholder's Signature

Physician's Name _____

Telephone No. _____

Date _____

Physician's Stamp and Signature

Orient Insurance PJSC
P. O. Box 27966, Dubai, U. A. E.
Tel: +971 4 2531300 Fax: +971 4 251 50 79
E-mail : aoic@alfuttaim.co.ae
Web: www.insuranceuae.com

CHECKLIST

Completed **"Claims Reimbursement Form"**

Full and Complete Medical Report/Diagnosis/Discharge summary from the treating doctor

Original itemized invoices or receipts for the amount claimed (Invoice must show cost per service).

Personalized SOAP/Maternity SOAP/Dental SOAP (if applicable)

Copies of results of diagnostic tests

For treatment within UAE, please submit your claim **within 60 days** from the date of treatment. For treatment outside UAE, the claim must be submitted **within 90 days** from the date of treatment.

IN-HOSPITAL NON-EMERGENCY ADMISSION

The MedNet Claims Centre should be notified, at least 7 days in advance for arranging elective treatment on free access basis at a network facility outside UAE (where applicable).

Within UAE (24 hours a day, 7 - days a week)

Toll Free Phone - 800 4882
Toll Free Fax - 800 4883

Outside UAE (24 hours a day, 7 days a week)

Phone - 00971 4 3900749
Fax - 00971 4 3908598

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