



## Reimbursement Claim Form

Please complete all the fields

Tel: +971 4 307 4111, Fax: +971 4 346 4669. Our helpline (24 hours): 80043444 (Toll Free), +971 4 307 4222

| PATIENT INFORMATION                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                   |                      |                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------|
| Date:                                                                                                                                                                                                                              | Healthcare Provider:                                                                                                                                                                                                                                                                                                              | Patient's Email:     |                                                            |
| Patient's Name (as on card):                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                   | Mobile Number:       |                                                            |
| EID/Card No:                                                                                                                                                                                                                       | <div style="display: flex; justify-content: space-between; width: 100px;"> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> | Date of Birth:       | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| IBAN Number:                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                   | Account Holder Name: |                                                            |
| Bank Name:                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                   | SWIFT Code:          |                                                            |
| Reason for Not using Almadallah Healthcare Facilities: <input type="checkbox"/> Emergency <input type="checkbox"/> Family Doctor <input type="checkbox"/> Preferred Personal Choice <input type="checkbox"/> Service not available |                                                                                                                                                                                                                                                                                                                                   |                      |                                                            |
| <input type="checkbox"/> On Vacation/business Trip Outside UAE <input type="checkbox"/> Other(s), please specify:                                                                                                                  |                                                                                                                                                                                                                                                                                                                                   |                      |                                                            |

| INFORMATION <span style="float: right;">To be completed by Physician</span> |                                                                                                                                                                                                           |                  |                                     |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------|
| Date of present symptoms:                                                   | <div style="display: flex; justify-content: space-between; width: 100px;"> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> |                  | Symptom(s) as described by Patient: |
| Pre-existing Condition(s) being treated for:                                | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                  | If Yes, Specify: |                                     |
| Chronic Medications:                                                        | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                  |                  |                                     |
| Family History of any illness:                                              | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                  |                  |                                     |

| OBJECTIVE/ASSESSMENT <span style="float: right;">To be completed by Physician</span> |                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clinical Findings:                                                                   |                                                                                                                                                                                                                                                               |
|                                                                                      |                                                                                                                                                                                                                                                               |
| Cause                                                                                | <input type="checkbox"/> Physical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive <input type="checkbox"/> Psychiatric <input type="checkbox"/> Dental <input type="checkbox"/> Work Related |
| <input type="checkbox"/> Other(s), Explain                                           |                                                                                                                                                                                                                                                               |
| Assessment/Diagnosis                                                                 | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected                                                                                                                         |
| 1-                                                                                   |                                                                                                                                                                                                                                                               |
| 2-                                                                                   |                                                                                                                                                                                                                                                               |

| MEDICAL PLAN <span style="float: right;">(Itemized Original Invoices &amp; Applicable Prescriptions / Reports / Results must be enclosed to consider the claim)</span> |                            |              |        |          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------|--------|----------|
| Type of Service                                                                                                                                                        | Name & Address of Provider | Service Date | Amount | Bill No. |
|                                                                                                                                                                        |                            |              |        |          |
|                                                                                                                                                                        |                            |              |        |          |
|                                                                                                                                                                        |                            |              |        |          |
| Currency (if treatment availed outside UAE)                                                                                                                            |                            |              | Total  | 0        |

| IN-PATIENT <span style="float: right;">(Discharge summary, itemized invoices, reports, results should be attached)</span> |           |       |
|---------------------------------------------------------------------------------------------------------------------------|-----------|-------|
| Length of stay:                                                                                                           | Provider: | Cost: |

The above information is true to the best of my knowledge. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical conditions & history to **ALMADALLAH** for the purpose of determining insurance benefits.

|                          |                                                                                                                                                                                                          |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Treating Physician Name: | Patient/Guardian Signature:                                                                                                                                                                              |
| Tel./Fax/Email:          |                                                                                                                                                                                                          |
| Signature & Stamp        | <b>Note:</b><br>1. Claims to be submitted within 60 days from the service date.<br>2. In case of online submission, kindly retain the original documents as they may be required to finalize your claim. |
| Date:                    | Date:                                                                                                                                                                                                    |