



Reimbursement Claim Form

Patient Information

Date :	Health Provider :	Patient's E-mail :
Patient's Name (as on card) :		Gender : ☐ Male ☐ Female
EID/Card No. :	Date of Birth :	Mobile No. :

Bank A\C Information

Account Holder Name :	Swift Code :
IBAN No. :	Bank Name :
Reason for not using Almadallah Healthcare Facilities : ☐ Emergency ☐ Family Doctor ☐ Preferred Personal Choice ☐ Service not available	
☐ On Vacation/business Trip Outside UAE ☐ Other(s), Please Specify _____	

Third-party / Substitute account

Respected / Concerned Team,

Hereby letter is to confirm that I, Mr. / Ms. ,

, have no objection to

transfer the claims settlement amount to the bank account of below person / company.

Below are the bank details for the transfer to be done.

Account Holder Name :	Swift Code :
Account No. :	Bank Name :
IBAN No. :	Branch Name :
Tel. No. :	Signature :
Date :	

Information

To be completed by Physician

Date of present symptoms :			
Symptom(s) as described by Patient:			
Pre-existing Condition(s) being treated for:	☐ No	☐ Yes	If Yes, Specify:
Chronic Medications :	☐ No	☐ Yes	
Family History of any illness :	☐ No	☐ Yes	



Objective/Assessment

To be completed by Physician

Clinical Findings :

Cause : ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work Related
☐ Other(s), Please Explain

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected

1 :

2 :

Medical Plan

(Itemized Original Invoices & Applicable Prescriptions / Reports / Results must be enclosed to consider the claim)

Type of Service	Name & Address of Provider	Service Date	Invoice No.	Amount
Currency (if treatment availed outside UAE)			Total	

In-Patient

(Discharge summary, itemized invoices, reports, results should be attached)

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 :

Tel./Fax/Email :

Date :

Signature :

Patient/Guardian Name :

Tel. No. :

Date :

Signature :

Note:

1. Claims to be submitted within 60 days from the service date.
2. In case of online submission, kindly retain the original documents as they may be required to finalize your claim.