المظلة هيلثكير مانجمنت
ALMADALLAH
HEALTHCARE MANAGEMENT

Reimbursement Claim Form

استمـــارة التعـــويض

Tel: +9714 3074111 Fax: +9714 3464669, Help Line for 24 Hours: 80043444 (Toll Free), 04 3074222

Date: / /	Healthcare Provider:

PATIENT INFORMATION

Patient's Name (as on card):			Mobile Number:

Card/EID															Birth date: / / (dd mm yy)	Sex: ❑ M ❑ F

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_____	

CLAIMS PAYMENT DETAILS

Reimbursement Claims payment are made to Principal Member's Bank Account by Bank Transfer. Kindly update Principal Member Bank Account details through mobile app or online portal.

يتم سداد مطالبات السداد إلى الحساب المصرفي للعضو الرئيسي عن طريق التحويل المصرفي. يرجى تحديث تفاصيل الحساب المصرفي للعضو الرئيسي من خلال تطبيق الهاتف المحمول أو البوابة الإلكترونية

INFORMATION

To be completed by Physician

Date of present symptoms: / / (dd mm yy)	Symptom(s) as described by Patient:

Pre-existing Condition(s) being treated for:	❑ No	❑ Yes	If Yes	_____
Chronic Medications:	❑ No	❑ Yes	Specify:	_____
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), 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	Amount	Bill No.
Currency (if treatment availed outside UAE)_____			Total	

IN-PATIENT *(discharge summary, itemized invoices, report, 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:		***Patient/Guardian signature***
Tel./Fax:		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.
✍Signature & Stamp		
Date:		*Date:*