

# 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 the MedNet Program is consulting you for medical care and kindly requests you to complete this form.

<b>Diagnosis</b>	:	_____	
		_____	
<b>Date of onset of symptoms</b>	:	_____	
<b>If, hospitalized</b>	:	Date of Admission	Discharge
		_____	_____
<b>Case Management</b>	:	_____	
		_____	
<b>Actual Costs</b>	:	_____	
		_____	

**Treatment Plan**

Diagnostic Tests	Pharmaceuticals
_____	_____
_____	_____

\_\_\_\_\_  
Date

\_\_\_\_\_  
Cardholder's signature

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Physician's Stamp and Signature

\_\_\_\_\_  
Date



The preferred choice for  
healthcare solutions

### **CHECKLIST**

- Completed "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

### **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, if 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 - 00 971 4 3900749

Fax - 00 971 4 3908598