AL DHAFRA INSURANCE COMPANY P.S.C.

MEDICAL INSURANCE REIMBURSEMENT FORM

Patient's Name _____ **Member No**. _____

Contact Telephone No. _____ **Policy No**. _____

Expiry Date _____

Date of Treatment : _____

Diagnosis : _____

_____

_____

_____

Date of onset of Symptoms : _____

If, hospitalised : **Date of Admission** _____ **Discharge** _____

Actual Costs

Consultation	Diagnostic Procedures	Pharmaceuticals	In-Patient Services	Any other Medical Services

_____ _____

Doctor's Name, Signature & Stamp **Patient's Signature**

Date : ……/……./…… **Date** : ……/……../…….

AL DHAFRA INSURANCE COMPANY P.S.C.

CHECKLIST

- ☐ Completed “Medical Insurance Reimbursement Form”
- ☐ Full and complete Medical Report / Diagnosis / Discharge summary from the treating Hospital / Doctor
- ☐ Original itemized invoices or receipts for the amount claimed (invoice must show cost per service)
- ☐ Copies of results of diagnostic tests.

For treatment within UAE, please submit your claim within **30 days** from the date of treatment. For treatment outside UAE, the claim must be submitted within **60 days** from the date of treatment.

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