

REIMBURSMENT FORM

If you have any questions regarding this form or any other aspects of your cover, Please telephone $\bf NAS$ (+9712 6940700) or Toll Free 800 2311

Details of member/patient

Company name				
Patient's name	Membership number from your card			
Tel number	Date of birth / /			
Patient's relationship to member	Fax number			
Medical section (To be fully completed by patient's medical practitioner – all boxes must be completed in block capitals.)				
Diagnosis	Date symptoms first noticed			
If, hospitalized Date of Admission Date of Discharge	Treatment			
Practioner's Name	Tel Number			
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Medical practitioner's stamp			
Signature Date				
Total Cost of Treatment				
Please give the full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates. Please also advise any further treatment planned.				

Patient's declaration and consent

I confirm I am the patient/patient's spouse or guardian (if patient under 16 years of age) and wish to claim benefits and declare that all the particulars given above are to the best Of my knowledge. I hereby consent and authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements to NAS. I agree that a copy of this consent shall have the validity of the original.

Signature: Date:

Checklist

Completed reimbursement Form

Original invoices/receipts for the amount claimed

Full & Complete Medical Reports/ Diagnosis/ Discharge summary from the treating doctor Copies of results of diagnostic tests.

The claim form should be submitted within 60 days (if treatment is within U.A.E.) and 90days (if treatment outside U.A.E.) of start of the treatment along with all original receipts/invoices – as per the policy membershipagreement. Claims will not be considered if not submitted within the stipulated time.

Send this claim form together with supporting material to:

SALAMA, Islamic Arab Insurance Company (P.S.C), Emerald Apartments Building, Suite 201, P.O.Box 10214, Dubai, UAE.

Ph: 04-3355300 Fax: 04-3343665