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.

Diagnosis : _____

_____

Date of onset of symptoms : _____

If, hospitalized : Date of Admission _____   Discharge _____

Case Management : _____

_____

_____

Actual Costs

_____

_____

Treatment Plan

Diagnostic Tests	Pharmaceuticals
_____	_____
_____	_____

_____
Date

Cardholder's signature _____

Physician's Name _____

Telephone No. _____

Physician's Stamp and Signature

Date _____

Strictly Confidential – Contains Medical Information.
Not To Be Duplicated or Handled By Unauthorized Personnel

a member of **MUNICH HEALTH**

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

For treatment within UAE, please submit your claim **within 60 days** from the date of treatment. For treatment outside UAE, the claim must be submitted **within 90 days** from the date of treatment.

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