المظلة هيلثكير مانجمنت
ALMADALLAH
HEALTHCARE MANAGEMENT

Reimbursement Claim Form

Please complete all the fields

Tel: +971 4 307 4111, Fax: +971 4 346 4669. Our helpline (24 hours): 80043444 (Toll Free), +971 4 307 4222

PATIENT INFORMATION

Date:	Healthcare Provider:	Patient's Email:
Patient's Name (as on card):		Mobile Number:
EID/Card No:	Date of Birth: *dd / mm / yyyy*	Sex: ☐ M ☐ F
IBAN Number:	Account Holder Name:	
Bank Name:	SWIFT Code:	

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:

INFORMATION *To be completed by Physician*

Date of present symptoms: *dd / mm / yyyy*				Symptom(s) as described by Patient:
Pre-existing Condition(s) being treated for:	☐ No	☐ Yes	If Yes, Specify:	
Chronic Medications:	☐ No	☐ Yes		
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	0

IN-PATIENT *(Discharge summary, itemized invoices, reports, 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/Email:	
Signature & Stamp	**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.
Date:	Date: