REIMBURSEMENT FORM

Tel: +971 4 4043232 Fax: +971 4 2367979

Provider Name: | Patient Name: | Policy No.:
Insurance Company: | Contact No.: | Policy Expiry Date:
Hospital File No: | MaxCare ID No.: | Company Name:

Year of Birth: / / | Gender: M ☐ F ☐

Please Complete Clearly (All Fields Mandatory)

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		
Date of Service:_____/_____/_____ (dd mm year)	Patient Tel:	DOB:_____/_____/_____ (dd mm year)	Sex: ☐ F ☐ M
Card No.		Patient Employer:	
(Mandatory) ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐		(*Mandatory*)	

SUBJECTIVE (*To be completed by Physician*)

Symptom(s) As Described by the Patient (CHIEF COMPLAINT)

Date of Present Symptom Onset: _____/_____/_____ (dd mm year)

What date did the Patient first feel same / similar Symptom(s):_____/_____/_____ (dd mm year)

Is the Patient under any type of Treatment? ☐ Yes ☐ No If yes, indicate what Assesment and since when:

OBJECTIVE/ASSESSMENT (*To be completed by Physician*)

Clinical Findings: Vital Signs: B/P: _____ T: _____ HR: _____ RR: _____

Cause: ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work Related ☐ Other

Assesment/Diagnosis: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected *INDICATE DIAGNOSIS NOT SYMPTOM*	*DIAGNOSIS CODE*
1.	
2.	
3.	

Is Assessment/Diagnosis related to another Assessment? ☐ Yes ☐ No If yes, specify: (i.e. Retinopathy related to Diabetes)

MEDICAL PLAN Itemized Orignal Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim.

☐ Consultation	*Cost*	☐ Physiotherapy	*Cost*
☐ Pharmacy	*Cost*	☐ Laboratory / Radialogy / Other	*Cost*
TOTAL CHARGES			

Was In-patient Required? Length of Stay _____ Indicate Provider _____ Cost _____

* Discharge Summary, Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name:

Tel / Fax: .....

Signature & Stamp: .....

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I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to MaxCare ME for the purpose of determining insurance benefits.

Patient's Signature (Parent if minor) *Date*