arab orient insurance company (p.s.c.)

MedNet

Claim Reimbursement Form

NAME OF GROUP:

Card Holder's Name: ______________________ Card No.: ____________________

Valid Until: ______________________ Contact Telephone: ______________

Settlement Cheque required in favour of : Principal Name ☐ Company's Name ☐

Name to appear on cheque ______________________ **Currency:**

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 : ____

(Attach all original receipts)

Treatment Plan

Diagnostic Tests	Pharmaceuticals
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
____	____

______________________ ______________________

Date Cardholder's Signature

Physician's Name ______________________

Telephone No. ______________________

Physician's Stamp and Signature

Date ______________________

MAIL ADDRESS: - **Arab Orient Insurance Company (psc).**
P. O. Box 27966, Dubai, U. A. E.
Tel: +971 4 2944457 Fax: +971 4 2940156
www.insuranceuae.com

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CHECKLIST

- Completed "**Claims Reimbursement Form**"(card no, members signature etc
- 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).
- Copies of results of diagnostic tests
- Prescription for medicine.
- Provide translation for claims, which are in languages other than English & Arabic.

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.

Claim settlement within 21 working days after the receipt of all required documentation.

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 (where 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 - 00971 4 3900749
Fax - 00971 4 3908598

REIMBURSEMENT CLAIM FORM –BANK DETAILS

In Compliance with Central Bank of UAE for the implementation of IBAN (International Bank Account Number), we request you to provide the IBAN of your bank account and confirm Email ID to which Explanation of Payment (Claims Report) will be sent.

Bank Name:	
Bank Branch Name:	
Bank Account Number:	
IBAN Number:	
SWIFT Code:	
Email ID (for sending explanation of payment):	

DISCLAIMER:

MedNet UAE confirms that our member account details as provided in this form will be used to only effect settlement of Insured Member's and their dependent's medical claims and hence will only be disclosed to MedNet's bankers and / or contracted foreign exchange companies.

INSURED MEMBER'S UNDERTAKING:

I hereby confirm that the above provided account details are accurate. I will be solely responsible for any errors in medical claims settlement arising out of or related to erroneous data provided above.

Signature of Insured Member: **Date :**