MedNet UAE FZ L.L.C.

Reimbursement Form

mednet
The preferred choice for
healthcare solutions

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. _____

Date _____

Physician's Stamp and Signature

a member of **MUNICH HEALTH**

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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

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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 :**