F M C NETWORK UAE

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Email – reimbursement@fmchealthcare.ae Helpline Number: 600-565691

MEDICAL INSURANCE TPA
IA.Reg.No:001

Medical Expenses Reimbursement Claim form

Instructions to fill the form

To be filled by the Treating Physician & Claimant
All documents must be in English or Arabic

Affix copy of front side of Insurance card

1	*Member Name*	
2	*Insurance Card Number*	
3	*Insured member Mobile Number*	*Mandatory*
4	*Age/Sex/Nationality*	
5	*Company Name &Employee Number*	
6	*Provider Name*	
7	*Address & Emirates*	
8	*Date of Visit*	

Clinical Details

Temp:..**°C** **BP:**... **mmHg** **Pulse:**...**/Min**

Signs & Symptoms :

Date of onset of illness : DD/ MM/YYYY

Type of Visit : **Emergency** **Work Related** **New Visit** **Follow up visit**

Diagnosis:

Management plan (Services inside the clinic including injections and investigations)

1	
2	
3	
4	
5	

Diagnostic Procedures referred outside If any:

Pharmaceuticals to be filled by treating Doctor Only ***(To be filled by the pharmacy)***

Sl.No	*Generic Name*	*Dose*	*Total Duration*	*Quantity*	*Price*
1					
2					
3					
4					
5					

(Attach prescriptions)

Doctor's Name and signature with seal:

***Beneficiary bank account details/ Company bank account details (If the member not having bank account) - Mandatory.**
We will not accept salary prepay account. Members having salary prepay account are requested to provide company bank account details with No objection letter from member at the time of claim submission.

Relation with Member			
Bank Name			
Account Name			
IBAN Number (23 Digits):			
Account Type:	***Savings***		***Current***

Declaration by Claimant:
I hereby authorize the physician and healthcare provider to file this claim for medical services on my behalf and I confirm that the above -mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize the Physician/Healthcare Provider or any other person who has provided medical services to me to furnish any and all information with regard to medical history, medical condition or medical services and copies of medical records upon request. All the informations pertaining to the claim submission (medical services,reports, investigations,prescriptions,invoices) are related to the treatments adhered.

Also, confirms that the payment for the eligible services shall be trasferred to the bank account furnished above.

Signature of the Claimant: **Date:**

Name			
Contact No			
Date of Claim Submission	Date	Month	Year

List of Documents attached - Checklist

		Yes	**No**
1	Original claim form with final diagnosis signed by the Insured and the treating doctor	Yes	No
2	Original Invoices	Yes	No
3	Hospital payment receipt with receipt number (Credit card receipt with signature if any)	Yes	No
4	Discharge summary with summary of diagnosis, treatment n hospital with date of admission and discharge)	Yes	No
5	Investigation reports	Yes	No
6	Medicine prescription	Yes	No
7	Pharmacy Invoices	Yes	No
8	Police report for all RTA cases	Yes	No
9	Death Summary (Only in case of death during hospital stay)	Yes	No
10	Beneficiary Bank account details/ Company Bank account details are mandatory. Claim will not be considered as eligible for processing if the bank account details are not furnished at the time of claim submission.	Yes	No

Timeline for Claim submission

1	Service availed within UAE & Outside UAE: As per policy terms and conditions. Kindly refer the Policy Document.
2	Additional Documents submission : Within 3 days of documents request

Note : All documents shall be translated in English or Arabic before submission