Health / medical reimbursement form

Use this to claim back treatment you have already paid for. Submit within the period stated in your policy - most insurers allow 30 to 60 days.

OFFICE USE
Claim ref. _____

MEMBER

Patient full name _____ Date of birth _____

Policy / card number _____ Emirates ID number _____

Relationship to the policyholder

☐ Self ☐ Spouse ☐ Child ☐ Other

Mobile number _____ Email address _____

TREATMENT

Clinic or hospital name _____ Emirate / country _____

Treating doctor _____ Date of treatment _____

Type of treatment

☐ Outpatient ☐ Inpatient ☐ Dental ☐ Optical ☐ Maternity ☐ Pharmacy

Diagnosis or reason for the visit

_____

_____

Is this related to an accident?

☐ No ☐ Yes

Is this a pre-existing condition?

☐ No ☐ Yes ☐ Not sure

AMOUNT CLAIMED

Total amount paid _____ Currency _____

Number of invoices attached _____

WHERE TO PAY THE SETTLEMENT

Complete only if the settlement is to be paid to you directly. Payments are made to the policyholder unless the insurer directs otherwise.

Account holder name _____ Bank name _____

IBAN _____ Account number _____

DOCUMENTS TO ATTACH

- [ ] Original itemised invoices, stamped and receipted
- [ ] Doctor's report or discharge summary
- [ ] Prescription, for any pharmacy claim
- [ ] Laboratory or radiology reports, where relevant
- [ ] Emirates ID and insurance card, both sides
- [ ] Bank IBAN certificate or a stamped bank letter

DECLARATION

I declare that the information given on this form is true and complete to the best of my knowledge. I understand that giving false information may invalidate the claim and the policy. I authorise Masters Insurance Brokers to pass this form and the attached documents to the insurer and to act on my behalf in progressing this claim. I consent to the insurer obtaining medical information relevant to this claim from any treating provider.

Signature

Date

Name in block capitals