دبـــــي للتـــــأمـــين
DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

DubaiCare

REIMBURSEMENT FORM

Medical claim · Membership number is compulsory

1 PATIENT DETAILS

PATIENT'S NAME

MEMBERSHIP NUMBER *

HEALTHCARE PROVIDER

TELEPHONE NO.

DATE OF SERVICE __ /__ /____

DATE OF BIRTH __ /__ /____

SEX ☐ M ☐ F

2 MEDICAL SECTION

To be completed by the medical practitioner

SYMPTOMS & DIAGNOSIS

DETAILS OF PHYSICAL FINDINGS

DETAILS OF INVESTIGATIONS DONE

DETAILS OF TREATMENT DONE

ⓘ Itemised original receipts and applicable prescriptions / reports / results must be enclosed to consider the claim.

3 MEDICAL PRACTITIONER

MEDICAL PRACTITIONER'S NAME & ADDRESS

TEL.

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

SIGNATURE AND STAMP OF THE MEDICAL PRACTITIONER

DATE __ /__ /____

4 PATIENT'S DECLARATION & CONSENT

I confirm that I am the patient / patient's parent or guardian and wish to claim benefits, and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to DubaiCare. I agree that a copy of this consent shall have the validity of the original.

SIGNATURE OF THE PATIENT

DATE __ /__ /____

5 PAYMENT DETAILS

Choose one option

☐ **Bank transfer** — please furnish the details below

BENEFICIARY NAME

BENEFICIARY ADDRESS

ACCOUNT NO.

SWIFT CODE

IBAN A E

BANK NAME

BRANCH NAME

☐ **Cheque** — please tick

☐ Account payee cheque
If you have a bank account only

☐ Cash cheque

BEFORE YOU SEND

- ☐ Membership number filled in
- ☐ Original itemised receipts
- ☐ Prescriptions / reports / results
- ☐ Practitioner & patient signatures