NGI
الشركة الوطنية للتأمينات العامة (ش م ع)
NATIONAL GENERAL INSURANCE CO. (PSC)

HealthNet

CLAIM FORM: REIMBURSEMENT OF MEDICAL EXPENSE

INSTRUCTIONS:

- Please send the duly filled Form along with the following supporting documents within 90 days of the expense incurred date:

  a. Proper Itemized bill(s) and payment receipt(s) which should be issued on the official bill/ receipt book of the Hospital/ Physician/ Surgeon/ Pharmacy/ Laboratory
  b. Laboratory or Radiology reports along with doctor's reference for the same.
  c. Itemized bills of Pharmacy/ Medicines supported by Physician's prescription specifying the quantity and respective dosage.
  d. Hospital Discharge Summary/ Clinical Summary (in case of hospitalization)
  e. Copy of Pre- authorization Letter (in case of Elective Inpatient Treatment)
  f. Copy of Birth Certificate (in case of child birth)

- If you have any difficulty filling this form, please call our Customer Service Desk during the office hours (08:00 am to 05: 00 pm except Friday & Saturday) **Tele: +971 4 2222 772**

Section – 1: Policyholder's Details (to be completed by Main Member)

1- HealthNet Policy / Card No:

2- Name of Policyholder (MAIN MEMBER/ EMPLOYEE)

First Name Middle Name Last Name

3- Relationship with the Patient: _____ **4-Total Amount Claimed**: AED _____

5- Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so, name the companies or association or source, and give amount of benefit payable by each.

(a) Name of Insurer/ other Source: _____
(b) Period of Cover: ____/____/____To ____/____/____ (c) Total Annual Benefit: AED_____
Day Month Year *Day Month Year*

Declaration/ Authorization:

I certify that all information contained in/ provided with the claim form is complete and correct. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other organization or person who has medical record or information about me and/ or of my family members (if covered under HealthNet Insurance Policy) to furnish it to **National General Insurance Co. (PSC)**. Any photocopy of this declaration/ authorization shall be deemed as effective as the original.

_____
Signature of Policyholder/Employee
(Self & on behalf of Family Member)

DATE: ___/___/_____
Day Month Year

_____
Signature & Seal of the Employer/ Sponsor
(For Group Scheme)

DATE: ___/___/_____
Day Month Year

Section – 2: Patient's Details (to be completed by Treating Doctor)

1- Name of Patient: _____ Date of Birth: ___/___/_____
Day Month Year

2- Name of Treating Physician/ Surgeon: _____ License /Registration No: _____

3- Name & Address of Hospital/ Clinic: _____

_____ **Telephone No:** _____ **Fax No:** _____

4- Are you the patient's primary physician? ☐ **Yes** ☐ **No**

5- In case of Elective (SCHEDULED) Treatment, was pre- authorization taken? ☐ **Yes** ☐ **No**

6- When did the symptoms first appear? ___/___/_____
Day Month Year

7- Has the patient ever suffered from or treated for the same or related condition? If yes, please provide details with dates:

S. No	Name of Illness/ Disability & Treatment received	Period of Disability/ Treatment						Remarks
		From			*To*			
		D	*M*	*Y*	*D*	*M*	*Y*	
1.								
2.								
3.								

8- **In Case of Hospitalization**: Date of Admission: ___/___/_____ Date of Discharge: ___/___/_____
Day Month Year *Day Month Year*

9- (a) Primary Diagnosis_____ (b) Secondary Diagnosis _____

10- Details of Clinical Procedure (Surgical/ Obstetrical Procedure): _____

11- Is further treatment required? If yes, Please specify _____

_____
Signature & Seal of Treating Physician/ Surgeon

DATE: ___/___/_____
Day Month Year

Section – 3: For Office Use Only (to be completed by Claims Manager)

_____
Claims Manager's Signature
DATE: ___/___/_____
Day Month Year

_____
Authorized Signatory's Signature
DATE: ___/___/_____
Day Month Year