

Reimbursement Form (Medical Part)

Please Use **BLOCK** letters to fill this form, and ensure that all sections are completed.

Section 1 – Member Information

Patient name (as printed on card)		
Patient card number	DOB:	
Principal name (as printed on card)		
Principal contact information	E-mail:	Mob:

Section 2 – Medical Information

(To be fully completed by patient's medical practitioner – all boxes must be completed in BLOCK letters.)

Country of treatment	Provider name and contact information
Date when first symptoms were noticed	Physician name and contact information
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.	Physician signature and official stamp Date / /
Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s).	
Symptoms:	
Diagnosis:	
Treatment / investigation:	

Reimbursement Form (Financial Part)

Patient name	Card number
--------------	-------------

Section 3 – Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
1				5			
2				6			
3				7			
4				8			

Total claimed amount per currency:

Section 4 – Settlement (Kindly ensure bank details are in print form)

Settlement currency:		Settlement by: <input type="checkbox"/> Cheque <input type="checkbox"/> Wire Transfer	
(A) Bank name		(B) Account title	
(C) IBAN number / Account number		(D) SWIFT code	
(E) Bank address		(F) Beneficiary address	

Important Notes:

Please submit the medical reports from your treating physician, pharmacy prescriptions, investigations requests and their results, invoices with itemized breakdown and original receipts. In case of online submission, please retain the original documents as they may be required to finalize your claim.

NAS prior approval is required for all non-emergency hospitalizations. Before admission, you are kindly required to e-mail a detailed medical report and cost estimate of the proposed treatment on official letterhead duly signed and stamped by the treating physician to claimscenter@nas.ae.

For your convenience, bank account details are saved and available for edit on your profile page on **myNAS** portal (<https://my.nas.ae>).

Cheques are issued in the name of the principal and are valid for 6 months from the date of issue.

For transfers within the U.A.E., fields (A), (B) and (C) are mandatory. For transfers outside the U.A.E., please complete all fields in the settlement section above. In case IBAN is not available in the destination country (e.g. India), please enter bank account number in lieu of IBAN number.

Claim settlements in currencies other than your bank account currency may result in foreign exchange charges. Please check with your bank regarding these and any additional fees that may be charged by your bank on incoming remittances.

NAS bears no liability for any incorrect bank account details provided above. Furthermore, any charges related to corrective action shall be deducted from the final settlement.

I, the undersigned, confirm that I am the patient/patient's spouse or guardian (if patient is under 18 years of age) and I wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I authorize and request any hospital, physician, and any other health provider to furnish NAS Administration Services with the complete information including copies of their records in connection with medical treatment and/ or other services provided to me or to my dependent. I also agree that a copy of this consent shall have the validity of the original.

Signature of the principal and or spouse

Date / / 20