Reimbursement claim form

This claim form is not an admission of liability.

Please use a separate claim form for each separate visit to the doctor.

Prior approval no:
When pre-authorisation required.
NB: In-patient treatment must be pre-authorised

Date received:

Dear Doctor, we thank you for filling in medical sections B, C and D of this claim form and for signing, dating and stamping it.
Dear Member, we thank you for completing all other sections of this claim form and for signing and dating it. All fields on the front page are compulsory. We thank you in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership no:		Group/Company name:
Patient date of birth: dd/mm/yyyy	Gender:	Patient name:
Policy/Group no:	Plan:	Patient phone:
dd/mm/yyyy For reimbursement only Date of treatment:		For hospitalization only Date of admission: Date of discharge:

B. Medical section

Symptoms presented	Date the patient first became aware of any signs or symptoms for this condition: dd/mm/yyyy	Date on which the patient first presented to any doctor for this condition: dd/mm/yyyy
Medical condition/diagnosis		
Investigation (Describe necessary investigations requested to define the diagnosis)		

C. Treatment advised

Drugs	Dose	Frequency	Duration
Procedure (Please give details of medical procedures if any)			

D. Further treatment planned

Please give details of any further planned treatment

E. Other insurer's details

Is the treatment accident related? Yes ☐ No ☐	Is it covered under another insurance policy? Yes ☐ No ☐
If you have answered 'yes' to either of these questions, please give the name of the Insurance company involved.	

Patient's declaration

I confirm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance. I agree that a copy of this consent shall have the validity of the original.

Signature: Date:

Medical practitioner declaration

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.

Name: Stamp:

Signature:

Date:

The member must complete the back of this form

You can download an Acrobat Reader writable version of this form from the www.axa-gulf.com website.

This part of the claim form aims at gathering additional information on the member in order to facilitate the processing of the claim. We thank you in advance for providing us the most complete information.

F. Administrative specific to reimbursement claims

Amount claimed: Please ensure that the amount claimed here is supported by original invoices and prescription.
Cheque beneficiary name: (IN CAPITAL LETTERS)
Payment will be made in the currency defined in your plan unless we agreed otherwise in writing. In which currency was the treatment originally billed?
Member's and patient's details Patient's name and address

Telephone No:	Fax No:
Mobile No:	
Address to which payment should be sent if different from above:	

G. Medical providers details:

Name of medical provider:	Telephone no:
Address of medical provider:	Fax no:

H. If you are claiming for treatment received outside your area of cover, please answer the following questions:

(a) Country where the treatment took place

(b) The reason for the patient being abroad

(c) Date of departure and return to own area of cover: From : ___ / ___ /____ To : ___/___/____

Are you claiming cash benefit for in-patient treatment? Please tick Yes ☐ No ☐

If Yes, please enclose a hospital certificate confirming the dates of stay:

For AXA use only:

Batch no: Batch opening date:

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +974 412 8733, Bahrain +973 (17) 582 612, KSA +966 (1) 478 0282 quoting your group and membership numbers.
Claims must be submitted along with supporting documents within 90 days from date of service. Send this claim form together with supporting material to Medical Department, AXA Insurance, PO BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain or AXA Insurance PO BOX 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, PO Box 15319, Doha, State of Qatar

PB31449a/09.07