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

Date Received: Select Date

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 : 13/XC/35509/0/38/E/0		Group Name/ Company Name : Irham Medical Center Arjan
Patient DOB: 11-Jan-1991	Gender : Male	Patient Name : AHMED MOHSEN HUSSIEN REKABY MOHAMED
Policy/ Group No.#: Plan :		Patient Phone : 0509765667
Date Of Treatment : 20-Jun-2024	Admission Date: 20-Jun-2024	Discharge Date : 20-Jun-2024
Email Address : MohamedAhmed.Elkeblawy@sheraton.com		

B. Medical Section

Symptoms Presented

For medication refill.

A known CKD patient being managed in Saudi German Hospital and advised on 2weekly creatinine

Date the patient first became aware of any signs or symptoms for this condition: Select Date

Date on which the patient first presented to any doctor for this condition:: Select Date

Medical Condition/ Diagnosis:

Date	Doctor	ICD Code	Diagnosis	Notes
20-Jun-2024	Enomen Goodluck	N18.9	Chronic kidney disease, unspecified	
20-Jun-2024	Enomen Goodluck	I10	Essential (primary) hypertension	

Investigations((Describe necessary investigations requested to define the diagnosis):

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	Notes
00:00:00	00:00:00	82565	CREATININE SERUM	NA	NA	
00:00:00	00:00:00	84520	UREA SERUM	NA	NA	
00:00:00	00:00:00	9	GP Consultation	NA	NA	

C. Treatments Advised:

Drugs:

Generic/Dose/Form	Instructions	Duration	Quantity	Refill
NORVASC 5MG / (AMLODIPINE : 5 MG) CAPSULES (HARD GELATIN) ORAL / CAPSULES (HARD GELATIN) (30S, BLISTER PACK) / Tablets	Take 1Tablets 1Time(s) perDay For 30 Day(s) morning	30	30	

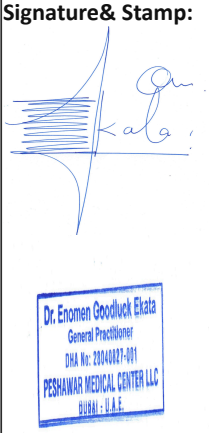
Procedure(Please give details of medical procedures if any):

D. Further Treatment Plan

E. Other Issuer Details :

Is the Treatment Accident Related ? ○ Yes ○ No	Is it covered under another insurance policy? ○ Yes ○ No

Patient Declaration	Medical practitioner 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.	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 :** Enomen Goodluck
Signature : 	**Signature& Stamp:**  20-Jun-2024

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 Details : Patient Name and Address:
Telephone : Fax :
Address to which payment should be sent if different from above:

G. Medical Provider Details:

Name of medical Provider: Irham Medical Center Arjan Address : Al salam Building, Al Barsha South, Arjan Near Miracle Garden, Dubai, United Arab Emirates. Telephone : 047700948 fax : 042974343

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 : *Select Date* to *Select Date*
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:

I. Payment details for bank transfer:

Bank Account Number :
Bank Name :
Bank Address :
Beneficiary Name:
Bank Sort/Swift Code :

AXA Use only

Batch No : Batch Opening Date: *Select Date*