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

FORM NO ZH.:

REIMBURSEMENT FORM FOR OUT OF NETWORK TREATMENT

INSTRUCTIONS: Please read the following information carefully before filling the form
Please fill Section A of this form and request your doctor to fill up Section B.
Please attach the following supporting documents to your claim form:

a. Original Itemized Bills / Invoices
b. Original Payments Receipts / Credit Card Slips
c. Original Prescriptions.
d. Original Discharge Summary
e. Copies of Laboratory and Radiology Reports
f. Copies of Operative Notes and Histopathology Report in case of surgery
g. Copy of Birth Certificate in case of Child Birth
h. Copy of Pre-authorization Letter from Health Net
i. Legal tranlsation of all documents in case originals are in any language other than Arabic or English

Please send your claim within 90 days of your treatment date to Medical Claims Department at the following address: National General Insurance Co., 5th Floor, NGI House, Port Saeed, Deira, P.O.Box 154, Dubai

If You have any difficulty filling this form, Please contact our Customer Service Desk during office hours(08:00 a.m to 05:00 p.m except Friday & Saturday) Telephone: +971 4 2115 800 or E-mail customerservice@ngiuae.com

Section - A: Policyholder's Details (to be completed by the insured)

1. HealthNet Policy / Card No:I038-000-115721598-01

2. Name of Policyholder: MYLA GONZALES ELIZARIO Date of Birth: 28-Dec-1981Sex:Female

3. Name of Employee (If different from Policyholder):.....

4. Patient's relationship to insured: ◉ Self ○ Spouse ○ Dependent ○ Child

5. Contact Numbers:(Mobile) 0522363934 (Others).....

6. E-mail address: s.ali@central-hotels.com

7. Total Claimed Amount (in original currency):

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
(Self & behalf of Family Member)
DATE:04-Dec-2024
Day Month Year

HealthNet

Signature & Seal of the Employer / Sponsor
(Optional for Group Scheme Only)
DATE:...../...../.....
Day Month Year

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Section - B: Patient's Details (to be completed by Treating Doctor)

1. Name of the Patient MYLA GONZALES ELIZARIO Date of Birth:: 28-Dec-1981 Sex: Female

2. Name of the Treating Physician / Surgeon: Enomen Goodluck Speciality: 999-9999-9999999-9

Licence / Registration No: DHA-F-0047965

3. Name & Address of Hospital / Clinic: CITICARE MEDICAL CENTER LLC

Telephone No.: 047700948 Email address: support@visionsoftwares.com

4. Are you patient's primary physician? ◉ Yes ○ No

5.Presenting Complaints:.

PC: Joints pain, especially of both elbow joints and both wrist joints.

Also feeling tired recurrently.

Duration: 2months (12/09/2024).

There is no history of trauma.

Known hypertensive on routine maintenance medications.

She is not diabetic and has no other medical condition of note.

6.Duration of Symptoms:

7.Onset of Condition:.

8.Relevent Past Medical / Surgical History:

9.Diagnosis: Essential (primary) hypertension, Other long term (current) drug therapy, Vitamin D deficiency, unspecified, Rheumatoid arthritis, unspecified ICD Code I10, Z79.899, E55.9, M06.9

10.Etiology:

11.Plan / Details of Managment:

a. Procedure: CPT Code:

b.Laboratory Test:

c. Radiology / Investigations:

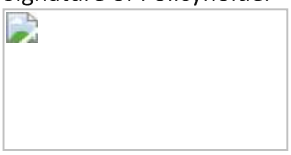
12. **In case of Hospitalization**:Date of Admission...../...../..... Date of Discharge...../...../.....
Day Month Year Day Month Year

Signature & Seal of Treating Physician / Surgeon
DATE: 04-Dec-2024
Day Month Year

Section - C For Office Use Only (to be completed by Claims Manager)

Remarks

Signature of Policyholder



(Self & behalf of Family Member)
DATE:...../...../.....
Day Month Year

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Signature & Seal of the Employer / Sponsor
(Optional for Group Scheme Only)
DATE:...../...../.....
Day Month Year