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

FOR

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: Nationa 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 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:I038-000-119903185-01

2. Name of Policyholder: HAMAD MOHAMMED ZAYED SULAIMAN ALEISSAEE Date of Birth: 07-Jul-1990Sex:Male

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

4. Patient's relationship to insured: (●) Self ( ) Spouse ( ) Dependent ( ) Child

5. Contact Numbers:(Mobile) 0501006026 (Others).....

6. E-mail address:

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 clinic or medical provider, any insurance company or any other organization or person who has medical record or information a and / or of my family members (if covered under HealthNet Insurance Policy) to furnish it to National General Insurance Co.(PS photocopy of this declaration / authorization shall be deemed as effective as the original.

Signature of Policyholder
(Self & behalf of Family Member)
DATE:19-Jul-2025
Day Month Year

HealthNet

Signature & Seal of the Employer
(Optional for Group Sch
DATE:...../.....
Day Mo

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

1. Name of the Patient HAMAD MOHAMMED ZAYED SULAIMAN ALEISSAEE Date of Birth:: 07-Jul-1990 Se

2. Name of the Treating Physician / Surgeon: KEERTHANA 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 ear wax right ear

No associated pain or itching

O\E ear debris present both ears

6.Duration of Symptoms:

7.Onset of Condition:.

8.Relevent Past Medical / Surgical History: , ,

9.Diagnosis: Impacted cerumen, bilateral ICD Code H61.23

10.Etiology:

11.Plan / Details of Managment:

a. Procedure: CPT Code:

b.Laboratory Test:

c. Radiology / Investigations:

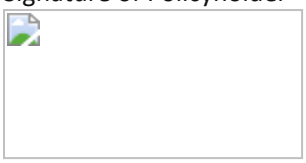
12. **In case of Hospitalization**:Date of Admission:...../...../..... Date of Discharge...../...../.....
Day Month Year Day Month Year

Signature & Seal of Treating Physician / Surgeon
DATE: 19-Jul-2025
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
(Optional for Group Sch
DATE:...../.....
Day Mo