



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:

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 Doctor, 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 in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership No : 13/XC/35522/0/4	Group Name/ Company Name : Irham Medical Center Arjan	
Patient DOB: 22-Jul-2023	Gender : Male	Patient Name : RAHEEM MUBARAK
Policy/ Group No. #: Plan : Patient Phone : 0509765667		
Date Of Treatment : 22-Oct-2023 Admission Date: 22-Oct-2023 Discharge Date : 22-Oct-2023		
Email Address : mohammed.bassiony@sheraton.com		

B. Medical Section

Symptoms Presented severe cough and sneezing since two days started on 19/10/2023	Date the patient first became aware of any signs or symptoms for this condition: Select Date	Date on which the patient first presented to doctor for this condition: Select Date
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Medical Condition/ Diagnosis:				
Date	Doctor	ICD Code	Diagnosis	
22-Oct-2023	Mohammadmahdi	R05	Cough	
22-Oct-2023	Mohammadmahdi	R50.9	Fever, unspecified	
22-Oct-2023	Mohammadmahdi	J21.9	Acute bronchiolitis, unspecified	

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

Start Time	End Time	CPT Code	Treatment	Teeth No	Sur
00:00:00	00:00:00	10	SP Consultation	NA	NA
00:00:00	00:00:00	0188-135906-2441	PULMICORT	NA	NA
00:00:00	00:00:00	0006-124513-2071	VENTOLIN NEBULES	NA	NA
00:00:00	00:00:00	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	NA	NA
00:00:00	00:00:00	0005-111805-1021	CHLOROHISTOL 10MG	NA	NA
00:00:00	00:00:00	96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	NA	NA

C. Treatments Advised:

Drugs:

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
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Patient Declaration	Medical practitioner declar
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 : Mohammadmahdi
 Signature :	Signature& Stamp:  Dr. Mohammadmahdi Ghodstehrani Specialist Neonatology DHA No: 00045407-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E. 22-Oct-2023

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, 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
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