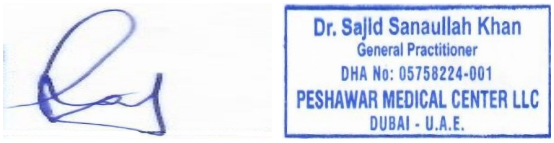
REIMBURSEMENT CLAIM FORM

If you have any questions regarding this form or any other aspects of your cover,
Please telephone NAS (+9712 6940700) or Toll Free 800 2311

Administrative section (to be completed fully by the employee/guardian)

Employee Name: Sajid Sanaullah	Insurance Card No of the person who received treatment (It is different for each member of the family): 1313-LPMM-VMVP-5VAE
Patient s name and address: VINOD PRASAD JAGAT RAM	
	Employee No/ Staff ID: 38
Company Name of the Employee : Irham Medical Center Arjan	Date of birth : 04-May-1969
Employee's Email address :	Employee's Tel number :
Nationality 176	

Medical section (To be fully completed by patient's medical practitioner – all boxes must be completed in block capitals.)

Physician s name and address: Sajid Sanaullah 999-9999-9999999-9	Date symptoms first noticed
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.	Physician s Signature and stamp 
	Date : 22-Oct-2023

Diagnosis
Acute bronchitis, unspecified, Acute maxillary sinusitis, unspecified, Tinea corporis, Cough, Wheezing, Type 2 diabetes mellitus without complications

Other insurer's details (If the treatment is accident-related or covered under another insurance policy please provide name of insurance company.)

Financial Section (to be completed by the employee/guardian)

Out Patient Treatment	Claimed Amount and Currency	**In Patient Treatment**	Claimed Amount and Currency
Consultation	0.00	Hospital charges/ Room	0.00
Pharmacy	0.00	Surgery/Anesthesia/OT	0.00
Diagnostic/Lab/Others	0.00	Drugs/Labs/Others	0.00
Country of Treatment			
Total Claimed Amount and Claimed Currency		0.00	

Patient's declaration and consent

I confirm I am the patient/patient's spouse or guardian (if patient under 16 years of age) and wish to claim benefits 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 NAS. I agree that a copy of this consent shall have the validity of the original.

Signature

Date: 22-Oct-2023

GENERAL INSTRUCTIONS

1) Please read the form carefully and make sure to complete all important information. NAS cannot process any incomplete application (i.e. lacking information and documentation). For complete list of requirements refer to statement no. 3.

2) Use a separate form for each Insured Member. Reimbursement Claim Forms can be obtained from your Insurance Company. If you have any questions regarding this form or any other aspects of your cover, please telephone NAS (+9712 6940800) or Toll Free 800 2311.

3) Submit the following essential documents along with your duly filled Reimbursement Claim Form:

Copy of your Insurance Card

Itemized bill/invoices (especially for lab, pharmacy, dental treatment, radiology tests) with date clearly mentioned in handwritten invoices. Receipts for the invoices clearly indicating the amount paid. Original medication prescription given by the treating doctor Investigation results/reports like laboratory test, x-ray, etc.

Medical report/ discharge summary stamped and signed by the doctor for hospitalization cases only

Copy of passport showing exit and re-entry to UAEor any other similar documents (e.g. e- gate) for treatment outside UAE only

Documents written in other languages are required to be translated to English or Arabic only

4) Please submit the completed documents