



P. O. Box : 43840, Abu Dhabi, U. A. E., Ph No. : (971) 2 6742102, Fax : (971) 2 6742103

## REIMBURSEMENT CLAIM FORM

Please give the following information correctly and completely to enable the company to process your claim promptly

1- Name of the Company / Main Member (In whose name policy is issued, Name of the Company in case of Group policy)	Name of Insurance Co.
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2- Details of the Insured Member ( In respect of whom claim is made)
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Patient's Name and Address	Membership No. (UHID No.)
	Relationship with insured

Policy No.	Date of Birth
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Other Insurance Coverage Yes/No (If yes attach details)	Gender (Male / Female)
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Employee Number (Group Policy)	Telephone Number
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3- Name & Address of the Provider
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4- Date of Admission / Service	Date of Discharge
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5- Amount Claimed	Currency
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### TO BE COMPLETED BY TREATING DOCTOR

6- Diagnosis
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7- Details of Disease / Illness contracted or injury suffered
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<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Congenital <input type="checkbox"/> Others
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8- Date of injury sustained or Disease / Illness first detected
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9- Infertility treatment taken for the present pregnancy ( for Maternity Claims) <input type="checkbox"/> Yes <input type="checkbox"/> No
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10- Investigations Done
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11- Treatment Given
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12- Name of Doctor
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13- Sign and Stamp of Doctor	Telephone No.
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**TO BE COMPLETED BY DENTAL PRACTITIONER**

<b>14- Details of Disease/Illness contracted or injury suffered.</b>
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<b>15- Details of injury sustained or Disease / Illness first detected (dd/mm/yy)</b>
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Type of Treatment	Amount	Type of Treatment	Amount
Extraction		Filling	
Neurectomy		Gum Treatment	
X-ray		R.C.T	
Cleaning		Scaling	
Bridge		Orthodontics	
Dentures		Crown	
Restoration		Prophylaxis	
Others		<b>TOTAL CLAIMED AMOUNT</b>	

<b>16- Other Investigations Done</b>
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<b>17- Name of Doctor</b>
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<b>18- Sign and Stamp of Doctor</b>	<b>Telephone No.</b>
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**PAYMENTS DETAILS**

<b>Have you personally had to pay costs for the treatment that you are claiming for?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>If yes, and you are personally seeking reimbursement, please provide following details:</b>
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<b>Name of your bank</b>	<b>Account number</b>
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<b>Address for your bank</b>
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<b>Name of Account holder</b>	<b>BIC number</b>
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<b>Bank sort code</b>	<b>IBAN number</b>
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<b>Currency of bank account</b>	<b>Routing code / Swift code</b>
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**MEMBER'S DECLARATION**

I declare that all the details given in this claim form are true accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorize any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by Wapmed / Insurer. I confirm and agree that any personal information collected or held by Wapmed / Insurer, whether given in this form or collected in any other way, may be used by Wapmed / Insurer, or disclosed to or transferred to any organization for the purpose of i) assessing this claim and giving ongoing insurance cover, customer service and the processing of future claims, ii) processing and making payments, and iii) providing marketing communications in respect of Wapmed / Insurer, its related products and services and those of its associated companies.

<b>Member's Signature</b>
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**Date (dd/mm/yy)**