Reimbursement Form (Medical part)

Please Use BLOCK letters to fill this form, and ensure that all sections are completed.

Section 1 - Member Information

Patient name (as printed on card)		
Patient card number		DOB
Principal name (as printed on		
Principal contact information	E-mail:	Mob:

Section 2 - Medical Information

(To be fully completed by patient's medical practitioner - all boxes must be completed in BLOCK letters.)

Country of treatment	Provider name and contact information
Date when first symptoms were noticed	Physician name and contact information
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 signature and official stamp Date / /

Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s).

Symptoms:

Diagnosis:

Treatment / investigation:

Patient name	Card number

Reimbursement Form (Financial Part)

Section 3 - Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
Total claimed amount per currency:							

Section 4 - Settlement (Kindly ensure bank details are in print form)

Settlement currency:	Settlement by: ☐ Cheque ☐ Wire Transfer
(A) Bank name	(B) Account holder name
(C) IBAN number / Account number	(D) SWIFT code
(E) Bank address	(F) Beneficiary address

Important Notes:

Please submit the medical reports from your treating physician, pharmacy prescriptions, investigations requests and their results, invoices with itemized breakdown and original receipts. In case of online submission, please retain the original documents as they may be required to finalize your claim.

NAS prior approval is required for all non-emergency hospitalizations. Before admission, you are kindly required to e-mail a detailed medical report and cost estimate of the proposed treatment on official letterhead duly signed and stamped by the treating physician to claimscenter@nas.ae.

Cheques are issued in the name of the principal and are valid for 6 months from the date of issue.

For your convenience, bank account details can be saved and available for editing on your profile page on myNAS portal https://mynas.ntouch.cloud

For transfers within the U.A.E., fields (A), (B) and (C) are mandatory. For transfers outside the U.A.E., please complete all fields in the settlement section above. In case IBAN is not available in the destination country please enter bank account number in lieu of IBAN number. Please note that transfers outside the U.A.E. are subject to charges that may be applied by your bank.

NAS bears no liability for any incorrect bank account details provided above. Furthermore, any charges related to corrective action shall be deducted from the final settlement.

All Documents must be submitted in English or Arabic, documents in other languages must be translated prior to submission.

I, the undersigned, confirm that I am the patient/patient's spouse or guardian (if patient is under 18 years of age) and I wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I authorize and request any hospital, physician, and any other health provider to furnish NAS Administration Services with the complete information including copies of their records in connection with medical treatment and/ or other services provided to me or to my dependent. I also agree that a copy of this consent shall have the validity of the original.	Signature of the principal and or spouse Date / / 20