Reimbursement Form

Card Holder's Name: _____ Card No.: _____

Valid Until: _____ Contact Telephone: _____

To be completed by the treating Physician

Dear Doctor: The beneficiary participating in the MedNet Program is consulting you for medical care and kindly requests you to complete this form.

Diagnosis : _____

_____

Date of onset of symptoms : _____

If, hospitalized : Date of Admission _____ Discharge _____

Case Management : _____

_____

Actual Costs _____

_____

Treatment Plan

Diagnostic Tests	Pharmaceuticals
_____	_____
_____	_____

_____ _____

Date Cardholder's signature

Physician's Name _____

Telephone No. _____

Physician's Stamp and Signature

Date _____

Strictly Confidential – Contains Medical Information.
Not To Be Duplicated or Handled By Unauthorized Personnel

CHECKLIST

- ☐ Completed “Reimbursement Form”
- ☐ Full and Complete Medical Report / Diagnosis / Discharge summary from the treating doctor
- ☐ Original itemized invoices or receipts for the amount claimed (Invoice must show cost per service)
- ☐ Personalized SOAP / Maternity SOAP / Dental SOAP (if applicable)
- ☐ Copies of results of diagnostic tests

IN-HOSPITAL NON- EMERGENCY ADMISSION

The MedNet Claims Centre should be notified, at least 7 days in advance for arranging elective treatment on free access basis at a network facility outside UAE, if applicable.

Within UAE (24 hours a day, 7-days a week)

Toll Free Phone - 800 4882
Toll Free Fax - 800 4883

Outside UAE (24 hours a day, 7- days a week)

Phone - 00 971 4 3900749
Fax - 00 971 4 3908598