



الشركة الوطنية للتأمينات العامة (شركة مساهمة عامة)
NATIONAL GENERAL INSURANCE CO. (P.S.C.)

Form No.: ZH 30592



REIMBURSEMENT FORM FOR OUT OF NETWORK TREATMENT

INSTRUCTIONS: Please read the following information carefully before filling this form

Please fill **Section A** of this form and request your doctor to fill up **Section B**.

Please attach the following supporting documents to your claim form:

- a. Original Itemized Bills / invoices
- b. Original Payment Receipts / Credit Card slips
- c. Original Prescriptions
- d. Original Discharge Summary
- e. Copies of Laboratory and Radiology Reports
- f. Copies of Operative Notes and Histopathology Report in case of surgery
- g. Copy of Birth Certificate in case of Child Birth
- h. Copy of Pre-authorization Letter from HealthNet
- i. Legal translation of all documents in case originals are in any language other than Arabic or English.

Please send your claim within 90 Days of your treatment date to Medical Claims Department at the following address:
National General Insurance Co., 5th Floor, Union House Building, Port Saeed Road, next to Dutco house,
opposite Deira City Centre. P.O. Box 154, Dubai.

If you have any difficulty filling this form, please contact our Customer Service Desk during office hours (08.00 am to 05.00 p.m. except Friday & Saturday) Telephone: +971 4 2115 800 Fax: +971 4 2980 396 E-mail: customerservice@ngiuae.com

Section - A: Policyholder's Details (to be completed by the insured)

- 1. HealthNet Policy / Card No:
- 2. Name of Policyholder: Date of Birth: Sex:
- 3. Name of Employee (If different from policyholder):
- 4. Patient's relationship to insured: Self Spouse Dependent Child
- 5. Contact Numbers: (Mobile) (Others)
- 6. E-mail address:
- 7. Total Claimed Amount (in original currency):

Declaration / Authorization:

I certify that all information contained in / provided with the claim form is complete and correct. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other organization or person who has medical record or information about me and / or of my family members (if covered under HealthNet Insurance Policy) to furnish it to **National General Insurance Co. (PSC)**. Any photocopy of this declaration / authorization shall be deemed as effective as the original.

Signature of Policyholder
(Self & on behalf of Family Member)

DATE: / /
Day Month Year

Signature & Seal of the Employer / Sponsor
(Optional For Group Scheme only)

DATE: / /
Day Month Year



Section - B: Patient's Details (to be completed by Treating Doctor)

- 1. Name of Patient Date of Birth:: / / Sex: F M
Day Month Year
- 2. Name of Treating Physician / Surgeon:..... Licence / Registration No.:.....
- 3. Name & Address of Hospital / Clinic:.....
Telephone No.: Email address:.....
- 4. Are you the patient's primary physician? Yes No
- 5. Presenting Complaints:.....
- 6. Duration of Symptoms:.....
- 7. Onset of Condition:.....
- 8. Relevent Past Medical / Surgical History:.....
- 9. Diagonosis: ICD Code
- 10. Plan/Details of Management:
a. Procedure:..... CPT Code:.....
b. Laboratory Test:.....
c. Radiology/Investigations:.....
- 11. **In case of Hospitalization:** Date of Admission: / / Date of Discharge: / /
Day Month Year Day Month Year

Signature & Seal of Treating Physician / Surgeon

DATE: / /
Day Month Year

Section - C: For Office Use Only (to be completed by Claims Manager)

Remarks:

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Claims Manager's Signature

DATE: / /
Day Month Year

Authorized Signatory's Signature

DATE: / /
Day Month Year