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

Details of member/patient

Member's name Pradnya Vishal Navale	Membership number from your card 9 D 4 2 3 4 2 F E7 5 4 5 F A 0
Patient's name and address	
	HSBC Staff ID No: Category : Executive / Non-Executive : ( )
	Date of birth / /
Email address	Tel number
Patient's relationship to member	Fax number

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

Medical practitioner's name and address	Date symptoms first noticed 10/04/2023
Dr. Priyanka Kiran	Tel number
	Fax number
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. Signature Date 24/4/2023	Medical practitioner's stamp DENTISTREE Dr. Priyanka Kiran General Dentist DHA-00148697-002 DENTISTREE DENTAL CLINIC
Medical condition requiring treatment K05.00 (Acute gingivitis)	
Please give the date on which the patient first presented to any doctor for this condition 24/4/2023	
Please give the full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates. Please also advise any further treatment planned.	

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

Details of Claimed Amount

Out Patient Treatment	Amount	In Patient Treatment	Amount
Consultation	D1110 → 250	Hospital charges/ Room	
Pharmacy		Surgery/Anesthesia/OT	
Diagnostic/Lab/Others	D0330 → 150	Drugs/Labs/Others	
Total Amount in AED	400 AED	Total Amount in AED	

(Please specify if other Currency) (Scale and polish + Panoramic xray)

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 / /

The claim form should be submitted within 90 days of start of the treatment along with all original receipts/invoices, doctors prescriptions/lab reports – as per the policy membership agreement. Claims will not be considered if not submitted within 90 days of treatment being received. Send this claim form together with supporting material to:

HSBC Insurance Brokers Limited, Dubai Branch, Wafi Residence, Oud Al Mehta Street
P. O.Box – 24912, Tel – (9714) 3242600, Fax – (9714) 3241727