BUPA GLOBAL CLAIM FORM

Bupa

IMPORTANT INFORMATION

Return this form with original, or copy invoices via email, fax or post to; info@bupa-intl.com, Fax: +44 (0) 1273 820 517, or post: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, UK. Claims can also be submitted as eClaims via Membersworld.

Please ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if all sections of the claim form are not completed in full. The form should be returned to us within six months of the initial treatment date. **Please write clearly in black ink and BLOCK CAPITALS.**

Please complete a new / separate claim form for:

- ○ each patient
- ○ each in-patient / day-case stay
- ○ each medical condition
- ○ each currency

If you have more invoices, you do not need to send a further claim form. Just send the invoices with a covering letter stating the condition and payment instructions. If the condition continues for more than six months, we may request a new claim form to be completed.

We are unable to return original documents, but we will be happy to provide certified copies on request.

1 PATIENT'S DETAILS

(to be completed by the person undergoing treatment)

Patient membership number:

BI - - -

Group name (if applicable):

Title: MS

First name: MUSKAAN

Family name: NOORMA

Other names:

Date of birth: 12/11/02

Age last birthday:

Correspondence address:

Building:

Street:

Town / city:

Area code:

PO Box:

Region:

Country:

Email:

Telephone:

Is this your permanent residency address? Yes ◯ No ◯

Do you want all future correspondence sent to this address? Yes ◯ No ◯

Do you have a residence in the USA? Yes ◯ No ◯

In which country did the treatment take place? UAE

What is the currency of the invoice? AED

What is the total amount of the claim? 3500

DENTISTREE

2 MEDICAL DETAILS

(all sections must be completed by the doctor in overall charge of the patient's treatment)

Medical Practitioner's details:

Name:	DR. PARTIK PREMJANI
Address:	SHOP #3, AL WASL POINT VILLA #6, AL MINA RD 1, DUBAI UAE
Qualifications:	SPECIALIST ORTHODONTIST
Diagnosis:	Class I with crossy central incisor

Onset date when symptoms first noticed by patient: D D M M Y Y

When did the patient first see a doctor? D D M M Y Y

Details of treatment:	
Details of operation:	
Details of medication:	

Dental treatment

Annual check	○	Preventive	○
Major restorative	○	Orthodontics	✓
Accident / emergency treatment	○		

Details of treatment: Comprehensive orthodontic treatment to open space for my tooth

Hospital dates: Admission date: D D M M Y Y Discharge date: D D M M Y Y

Name and address of admitting hospital: Reference number:

Name:	DENTISTREE DENTAL CLINIC
Address:	[illegible]
Telephone:	04-2529935
Fax:	—
Email:	dentistree.dentalclinic@gmail.com

Medical practitioner's / dental surgeon's signature: Dr. Partik Premjani, Specialist Orthodontics, DHA-00058483-003, DENTISTREE DENTAL CLINIC

Date

3 CASH BENEFIT

The hospital should complete this section if you have stayed in hospital overnight without charge, and your plan includes a Cash Benefit.

I confirm that .....
was in hospital from ..... to .....
and this hospital did not charge for accommodation.

The hospital needs to stamp this claim form here:

4 PAYMENT DETAILS

IMPORTANT INFORMATION

We can settle claims in over 80 currencies. In a few cases where we cannot settle in the currency requested, we will reimburse you in the currency of your subscriptions.

Who would you like us to pay? *(please tick one only)*

Doctor / hospital ◯ Principal member ◯

Patient ◯ Group (if on a company plan) ◯

Please complete either Section A or Section B

Section A - Payment by cheque

In which currency would you like us to pay the cheque? (please tick one only)

Currency of your invoices ◯ Currency of your subscriptions ◯

Currency of your bank account ◯

Please specify this:

Cheques payable to members will be sent by post to the correspondence address provided on the front page.

Section B - Payment by Electronic Funds Transfer to a bank account

Bank name:

SWIFT / BIC code*:

Sort code (UK only): - -

Account number:

IBAN:

Account name / payee:

Currency for the transfer:

Bank address:

Post / Zip code:

Country:

***In order to process your payment as quickly and securely as possible, we strongly recommend that you provide both your IBAN and the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.**

We recommend that bank transfers are made in the currency of your bank account. If you have asked us to pay the provider, and an annual deductible applies to your cover, the deductible will be collected using your direct debit or credit card. We will instruct our bank to recharge the administration fee relating to the cost of making the electronic transfer to us, but we cannot guarantee that these charges will always be passed back for us to pay. In the event that your local bank makes a charge for an electronic transfer, we will aim to refund this charge. If we are unable to pay direct to a bank account, or no account details are provided, we will pay by cheque. We reserve the right to send any benefit due to an appropriate person – for example, the executors of the will of someone who has died or the dependant on your membership who has paid the bill.

5 YOUR CONSENT TO OBTAIN A MEDICAL REPORT

IMPORTANT INFORMATION

Please read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

In order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration below.

You can choose from three courses of action:

1. You can give your consent without asking to see the doctor's report before it is sent to us. The report will then be sent directly to us by the doctor.

2. You can give your consent, but ask to see any report before it is sent to us, in which case you will have 21 days, after we notify you that we have requested a report from the doctor, to contact your doctor to make arrangements to see the report. If you fail to contact the doctor within 21 days, he will be entitled to send the report direct to us. If however you contact your doctor with a view to seeing the report, you must give the doctor written consent before he can release it to us. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to us.
Should you give your consent to us obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.

3. You can withhold your consent but, if you did, please bear in mind that we may be unable to accept your claim.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask him within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your doctor may also make a reasonable charge for his services.

The undersigned authorises and requests any hospital, specialist, physician or other health provider to furnish Bupa or its duly authorised agent acting on Bupa's behalf with such information as Bupa or that agent may seek from them in connection with any treatment or other services provided to me or my dependant for the purpose of Bupa considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

Please indicate below if you wish to see a copy of the medical report before it is sent to Bupa:
I do wish to see a copy of any medical report before it is sent to Bupa. ◯
I do NOT wish to see a copy of any medical report before it is sent to Bupa. ◯

Bupa Global Data Protection Notice

Purpose: Personal data collected on you, and where appropriate, your family, will be used by Bupa Global to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa Group. To this end, Bupa fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be undertaken outside the EEA, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents; and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the Bupa Global Agent/Adviser where you have requested the Adviser to assist you.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

Telephone calls: In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Bupa Global, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and addresses: Bupa Global does not make the names and addresses of members or patients available to other organisations.

Keeping you informed: Bupa Global would, on occasion, like to keep you informed of Bupa products and services which it considers may be of interest to you.

Contact address: If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

6 THIRD PARTY INSURERS

Are some of the costs recoverable from someone else (for example, state insurer or a person / organisation involved in an accident?): Yes ◯ No ◯

Name:	
Address:	
Email:	
Telephone:	

7 DECLARATION

IMPORTANT INFORMATION - TO BE COMPLETED BY THE PATIENT

I confirm that the information I have given on this form is accurate and correct to the best of my knowledge.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, to process my personal information with respect to this claim.

Patient's signature (Parent or guardian if patient is under 16)

Date

If you have any queries regarding your claim, log onto our website www.bupa-intl.com/membersworld or contact our customer services team on:

- Telephone: +44 (0) 1273 323 563
- Fax: +44 (0) 1273 820 517
- Email: info@bupa-intl.com

Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.

Please refer to your membership certificate for details of your insurer.

DENTISTREE DENTAL CLINIC

TAX INVOICE

Reg TRN No : 100529934000003
Facility Name : DentisTree Dental Clinic
Address : P.O.Box 23581, Ground floor, Shop 3, Wasl Port Views 8, Al Mina Road, Jumeirah 1, Dubai
042529935 / 045641764

Invoice No	:	INV-1C007964	**Invoice Date**	:	16-08-2024
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Muskaan Noronha	**MRN #**	:	3907
Age / Gender	:	23Y - 9M - 18D / Female	**Type**	:	Cash
Visit Date	:	16-08-2024	**Inv. Time**	:	19:15:02

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	InvLit	Invisalign Lite- Down Payment		3,000.00	1	3,000.00	0.00	0	0.0000	3,000.00

Gross Amount (in AED)	**3,000.00**
Discount (in AED)	**0.00**
Net Amount (in AED)	**3,000.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**3000.00**
Paid (in AED) (Bank Transfer)	**3,000.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**0.00**

Prepared By Gayle

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.

DENTISTREE DENTAL CLINIC

3,000.00 **RECEIPT VOUCHER (No.REC-1007829)** Date:16-08-2024

Receive from Mr./Mrs./M/s. **3907 - Muskaan Noronha**

The sum of Dhs. **Three Thousand Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **3,000.00** / By Allocated **0.00**

Bank: Cheque No. Date: **16-08-2024**

Being

Made by **Gayle**

DENTISTREE DENTAL CLINIC

TAX INVOICE

Reg TRN No : 100529934000003
Facility Name : DentisTree Dental Clinic
Address : P.O.Box 23581, Ground floor, Shop 3, Wasl Port Views 8, Al Mina Road, Jumeirah 1, Dubai
042529935 / 045641764

Invoice No	:	INV-1C008080	**Invoice Date**	:	30-08-2024
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Muskaan Noronha	**MRN #**	:	3907
Age / Gender	:	23Y - 9M - 18D / Female	**Type**	:	Cash
Visit Date	:	30-08-2024	**Inv. Time**	:	13:11:42

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	65	ORTHODONTIC MONTHLY VISIT		600.00	1	600.00	100.00	0	0.0000	500.00

Gross Amount (in AED)	**600.00**
Discount (in AED)	**100.00**
Net Amount (in AED)	**500.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**500.00**
Paid (in AED) (Credit Card)	**500.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**0.00**

Prepared By Gayle

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.

DENTISTREE DENTAL CLINIC

500.00 **RECEIPT VOUCHER (No.REC-1007973)** **Date:30-08-2024**

Receive from Mr./Mrs./M/s. **3907 - Muskaan Noronha**

The sum of Dhs. **Five Hundred Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **500.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **30-08-2024**

Being

Made by **Gayle**

NEOPAY

DENTISTREE DENTAL CLINIC
PORT RASHID
DUBAI
POS ID:10131136 MID: 001030110690
DATE: 30/08/24 TIME: 13:02:39
SALE
VISA(Contactless)
454793****5393**
EXP: XX/XX
PAN SEQ No : 00
BATCH NO: 704 RECEIPT No :012136
RRN: 091753006391
AMOUNT: AED 500.00
PLEASE DEBIT MY ACCOUNT
NO SIGN REQUIRED FOR CONTACTLESS TXN
APPROVAL CODE: 001010
AID: A0000000031010
LABEL: Visa CREDIT
TVR: 0000000000 TSI: 0000
AC: 92BE906460870B8B CID: 80
THANK YOU
COME AGAIN
<<CUSTOMER COPY>>
APP VERSION:1.80