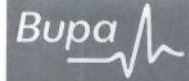


# BUPA GLOBAL CLAIM FORM



## 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:

First name:

Family name:

Other names:

Date of birth:

Age last birthday:

Correspondence address:

Building:

Street:

Town / city:

Area code:

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?

What is the currency of the invoice?

What is the total amount of the claim?





## 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 do, 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 agents 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:** Anonymous 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](mailto: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](http://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](mailto: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.



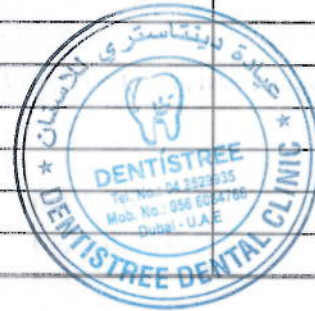
# DENTISTREE DENTAL CLINIC

## 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-1C008435 Invoice Date : 30-09-2024  
Doctor : Pratik Premjani Department : Dental  
Patient Name : Lilia Ishane MRN # : 1922.  
Age / Gender : 13Y - 10M - 24D / Female Type : Cash  
Visit Date : 30-09-2024 Inv. Time : 13:29:18

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	64	ESSIX RETAINER		1,000.00	2	2,000.00	1,200.00	0	0.0000	800.00
<b>Gross Amount (in AED)</b>										<b>2,000.00</b>
<b>Discount (in AED)</b>										<b>1,200.00</b>
<b>Net Amount (in AED)</b>										<b>800.00</b>
<b>Tax on 5%(in AED)</b>										<b>0.00</b>
<b>Total Amount(in AED)</b>										<b>800.00</b>
<b>Paid (in AED) (Credit Card)</b>										<b>800.00</b>
<b>Balance (in AED)</b>										<b>0.00</b>
<b>Advance Balance (in AED)</b>										<b>0.00</b>



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

800.00

RECEIPT VOUCHER (No.REC-1008345)

Date:05-10-2024

Receive from Mr./Mrs./M/s. 1922 - Lilia Ishane

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

By Cash **0.00** / By Credit Card **800.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank:           Cheque No.

Date: **05-10-2024**

Being

Made by **Gayle**



Lilia

**NEOPAY**  
powered by maestro المشرق

DENTISTREE DENTAL CLINIC  
PORT RASHID  
DUBAI

POS ID:1011136           MID: 001000110690  
DATE: 05/10/24           TIME: 13:24:31

**SALE**

**VISA(Contactless)**  
**475051\*\*\*\*\*2658**

EXP: XX/XX  
PAN SEQ No : 00  
BATCH NO: 740           RECEIPT No :012436  
RRN: 001786850950

**AMOUNT: AED 800.00**

PLEASE DEBIT MY ACCOUNT  
NO SIGN REQUIRED FOR CONTACTLESS TXN

**APPROVAL CODE: 422080**

AID: A0000000031010  
LABEL: Visa DEBIT  
TVR: 0000000000           TSI: 0000  
AC: F0221734D884E865           CID: 80

THANK YOU  
COME AGAIN

**<<CUSTOMER COPY>>**  
APP VERSION:1.80