ADNIC
شركة أبوظبي الوطنية للتأمين
ABU DHABI NATIONAL INSURANCE COMPANY

REIMBURSEMENT MEDICAL CLAIM FORM

Please read the instructions & guidelines on overleaf before filling the form

Voucher No.:

1. Patient's name: SOPHIE GERASHCHENKO **2. Patient's Health Card no./Emirates ID no.:**

3. Group member's name: 784-2011-9776204-0

4. Reason for not using listed Healthcare facilities: (kindly indicate)

☐ Emergency ☐ Elective ☐ Service not available ☐ On vacation/business trip outside the UAE

☐ Other(s) please specify ....

5. Medical information: (To be filled by treating doctor for all outpatient treatment. For cases like hospitalization procedures and surgeries, a detailed medical report is required)

Condition requiring treatment: K05.00

Visit date: 19/11/2024.

Onset and duration of illness: 3 days.

Treatment details: Consultation

I declare that I have attended to this patient and that the particulars given are to the best of my knowledge true and correct.

Name & signature of the doctor: HASHMIT KAUR Date: 19/11/2024. Stamp: ....

6. Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount
Dentistree Dental Clinic	1C0 08807	19/11/24	consultation	200
Gnd # 3, Al Wasl Port View Bldg #8				
Al Mina Rd 1, Jumeirah 1.				
Dubai UAE				

Currency (If treatment availed outside the UAE) AED .... **TOTAL** 200

7. Other information:

Is the above case work-related? ☐ No ☐ Yes (full details) ....

Is the claim covered by another insurance? ☐ No ☐ Yes (pls specify the amount reimbursed and by which insurance company)

8. Declaration:

I, the undersigned, hereby declare that the information above is true and complete and that reimbursement requested is for expenses paid by me for the treatment of my medical condition.

I agree to submit to ADNIC any mandatory/deemed necessary requested document to process my above claim. I hereby authorize ADNIC to approach any doctor/medical facility/any institution or any person who has any record/medical information about me or my family member, to provide ADNIC with complete information including copies of the records when requested.

Name Relationship to the card holder	Signature	Date	Contact no.	Email address

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Instructions

1. This form needs to be completed by the insured member (Card holder), only if the provider is not submitting the claim on his behalf.
2. Please read the form carefully and make sure to complete all pertinent information. ADNIC will not be able to process any incomplete Reimbursement Claim Form that lacks proper documentation.
3. Use a separate form for each Member.
4. All the documents including invoices and medical reports should be in either English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
5. The following documents to be attached to your duly filled Reimbursement Claim Form.
   - *Copy of Medical insurance card and Emirates ID.*
   - *Original itemized bill/invoices (dated) and receipts of payment.*
   - *Original prescription for medication given by the treating doctor (except for controlled drugs). Validity of the prescription is limited to 60 days and for controlled drugs limited to 3 days in line with Department of Health - Abu Dhabi.*
   - *Investigation requests/reports like laboratory tests, x-rays, etc.*

   Additional requirements to above:

   For Inpatient (Hospitalization Cases)
   - *Medical Report/Discharge Summary stamped & signed by the treating doctor.*

   For treatments availed Outside the UAE
   - *Proof of travel with date (E.g.: Copy of tickets/boarding pass/Exit & Entry page).*
   - *Elective treatment is subject to ADNIC prior approval at all times.*
6. Please retain copies of receipts and documents enclosed with your claim, as ADNIC will retain original documents.
7. All claims subject to reimbursement availed within or outside the UAE, should be submitted with 120 days of incurred treatment.
8. Please submit all the above required documents directly to:
   medicalclaims@adnic.ae

If you need assistance in filling this form, please call: 8008040

Instructions to complete the form

1. **Please write your name & Medical insurance card number** *as mentioned in the Card.*
2. **Medical Information** – *Request your treating doctor to fill up brief medical information about your condition and treatment.*
3. **Provider Name & Address** – *Kindly use more than one line if necessary to provide this information about each facility where you were treated.*
4. **Bill No.** – *Please write the serial number/reference number printed on the bill/receipt/invoice for each service separately.*
5. **Service Date** – *State date of treatment for each service against each bill.*
6. **Description of services** – *State type of service like consultation/Pharmacy/Investigations/Physiotherapy/Dental/ Hospitalization.*
7. **Amount** – *State the exact amount as appears on the invoices.*
8. **Total** – *Total amount of all the invoices submitted with this form for reimbursement from ADNIC.*
9. **Currency** – *Name of the currency in which actual payment was made.*
10. If treatment is due to a road traffic accident,, a police report is required to be submitted with this form.
11. **Declaration:** *Kindly write your name, signature, date, the contact number and relationship to the cardholder.*

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PREFERENCE – MODE OF SETTLEMENT

1. ☐ Cheque

2. ☐ Bank/Wire transfer

If Bank/Wire Transfer, please fill in the below authorization form.

AUTHORIZATION FORM FOR BANK/WIRE TRANSFER

Authorization

I, the undersigned, hereby authorize Abu Dhabi National Insurance Company (ADNIC) to wire transfer the amount of my claim under this form to the following bank account:

BANK NAME: .....

IBAN NUMBER: .....

EMAIL ID: .....

MOBILE NUMBER: .....

.....	.....	.....
Member Name & Medical insurance card number	Signature	Date

Disclaimer: All information provided is the responsibility of the member and is legally binding.

ADNIC OPS only
ADNIC staff name: Date: