

Reimbursement Claim Form

- Details and Contact Info	ormation
. Daman Member Details and Contact Info	of Albandon
ame:* AMINA KHAN ER MOHAMMAD MERA Exactly as on the Daman card)	13 ARIVIAO
Daman Card No:	Mobile No.:* 050 381900 3
mirates ID (EID):* 784 - 1971 - 5054918 - 2	
-mail Address:*	
2. Claims Payment Details	
Wire Transfer (Please provide the bank account or reimbursement claim.)	details to which Daman should transfer the money for this
Beneficiary Name:	
Bank Name:	Branch, Bank Address:
Dank Hamilton	Swift Code Number:
Account Number:	(For International Transfers)
IBAN:	-
respect of releasing the payment to the bank o	orm and hereby discharge Daman from any liability with details as specified by me hereinabove.
3. Medical Information	
Visit Date:	1 -00
Reason for visit/Chief Complaints: Pain &	broken trolle upper left back regi
Diagnosis: KO4.7- Penasical abscen	cultiout sims; Kos. 81- Cracked troth
Treatment Details: Eoot canal treatment	and - image -
Currency (If treatment is availed outside UAE):	Total Amount Paid: 8,840
4. Checklist – please check that you have	included all of the following as required: (Failure to
provide the required below documents may resu	ult in rejection or delay in the processing of your claim).
Invoices/bills with a breakdown of each medical	service and its unit cost. It must show a confirmation of
payment or a corresponding receipt.	Mary Mary Carlo
Complete Medical Report/ discharge summary o	or a precise identification of the illness (diagnosis) or
description of the symptoms by the doctor	EDD
	liances
☐ Prescription(s) for medications and medical app	THE RESIDENCE OF THE PARTY OF T
5. Terms & Conditions/Authorisation	for to the terms and conditions in page 2)
☐ I agree to the Terms and Conditions herein (I☐ I hereby authorise Mr. /Ms. /Companyrelated to this claim from Daman on my behalf.	refer to the terms and conditions in page 2) to receive medical information
Name of Daman member/ Legal Guardian/ Le Representative	egal Signature Date



Terms & Conditions:

I, declare that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition.

I, hereby authorise any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide the National Health Insurance Company - Daman with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalisation or any other information required by Daman.

I hereby declare that the information submitted to Daman is true and correct to the best of my knowledge. I am aware that any person who intentionally makes any false and/or misleading statements to obtain reimbursement from Daman shall be subject to fine and/or imprisonment in accordance with the UAE laws.

I am fully aware that in case I am not satisfied with the settlement of my Reimbursement Amount, I must contact Daman within 180 days from the date of receiving payment notification/rejection letter.

I agree that upon payment of the Reimbursement Amount, I shall transfer the ownership of my original documents to Daman and shall have no future claim against Daman with respect to these documents.

I also undertake that no claims will be made by any person or entity from Daman in future in relation to the aforesaid reimbursement claim. I undertake that in the event of any claim in future by any person to Daman for the Reimbursement Amount, Daman shall have no liability in this regard. I hereby indemnify and hold harmless, Daman and its directors, officers, employees, agents, representatives, assigns and successors from any direct or indirect costs, losses or expenses arising as a result of or in connection with the Reimbursement Amount or my reimbursement claim.

Notice:

We encourage you to **provide all the above required information** and any other **relevant documents** that support your claim, such as travel documents (for international reimbursement claim), diagnostic test and lab test results, etc.

Documents should be provided in **English or Arabic**. We will do our best to accommodate other languages, however you may be asked to provide translated documents by a professional.

All reimbursement claims have to be submitted within 180 days from the invoice date.

Please use our <u>Daman mobile application</u> or <u>Daman's website</u> to submit your future claims.

If you have any questions or need help completing the claim form, please contact us on:

Customerinfo@damanhealth.ae

600 5 32626 within the UAE or +971 2 6149555 outside UAE.

www.damanhealth.ae

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