

# Reimbursement Claim Form

## Dental



Submit your completed claim form and supporting documents online:  
HRDirect > Profile > Remuneration & Benefits > Medical Benefits > Member Portal > Submit Reimbursement claim

### Section A - Employee Details

Name of Employee

Staff Number

### Section B – Patient Details (To be fully completed by treating dentist)

Patient Name

Eva Fernandes

DOB

10.12.2017

Complaints /  
Onset / History

Diagnosis with tooth  
number

Removal of braces + fabrication of retainers



Mark the affected tooth with "X" and specify diagnosis details in the above field

| 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |

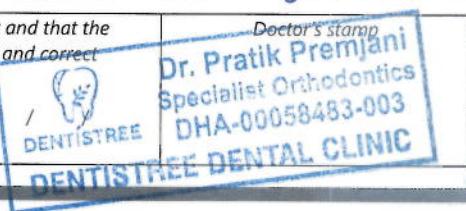
Planned Treatment

Removal of braces + fabrication of retainers.

Signature and Stamp

Signature

Date



### Section C – Patient / Spouse / Guardian Signature

I hereby authorise the Emirates Group to obtain any and all medical records, reports and test results, either in original hard-copy form or via access to electronic data systems, as may be required to validate my claim. I consent to the Emirates Group disclosing my medical records, reports and test results for the purpose of processing and validating my claim. In addition, I understand any such medical information provided to the Emirates Group will be accessible to Emirates Group employees (including employees of wholly owned subsidiaries) on the Emirates Medical Benefits System Employee Portal via confidential log-in.

Signature

Date / /

### Section D – Employee Checklist

| Employee check           | Documents Submitted                        |
|--------------------------|--|
| <input type="checkbox"/> | Claim form                                 |
| <input type="checkbox"/> | Payment receipts with costs breakdown      |
| <input type="checkbox"/> | Copy of x-ray film (.pdf)                  |
| <input type="checkbox"/> | Medical report and prescription            |
| <input type="checkbox"/> | EK referral (for EK Dental Clinic members) |