رؤيـة جديـدة / للتأمـين
redefining / insurance

Reimbursement Claim Form

1 ADMINISTRATIVE SECTION

Policy Number:	Membership Number:
Patient Name:	Provider Name:
Date of treatment:	Patient Gender:
Mobile Number:	Email Address:

2 MEDICAL SECTION

Type of visit: ☐ Outpatient ☐ Inpatient ☐ Emergency ☐ Maternity ☐ Dental ☐ Optical

If Pregnant: L.M.P. Date:	Nature of Conception:

Chief complaint:

History of present illness (please include duration, date of onset, and when the patient became aware of each condition)

Clinical findings/other conditions

Past medical history

Details of trauma - if applicable (when, where & how)

☐ Work related ☐ RTA related (include a police report) ☐ Sports related

If yes:
☐ Professional
☐ Non-Professional

Diagnosis

Treatment plan, recommended medications, investigations, and/or procedures

PATIENT DECLARATION

I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/information given above are to the best of my knowledge true and correct I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C © representative or any a AXA company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates to audit review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.

Signature	Date

MEDICAL PRACTITIONER DECLARATION

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Name	Signature
Date	

Stamp

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits/cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +97 (4) 412 8733, Bahrain +973 (17) 582 612, KSA +966 (1) 478 0282 quoting the policy and membership numbers. Claims must be submitted along with supporting documents within 30 days from date of service. Send this claim form together with supporting material to Medical Department, AXA Insurance, PO BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain or AXA Insurance PO BOX 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, PO Box 15319, Doha, State of Qatar.