MEDGULF
THE MEDITERRANEAN & GULF INSURANCE & REINSURANCE CO. B.S.C. (C)

NEXtCARE®
Your Health Managed with Care

REIMBURSEMENT ASOAP FORM

24 hour Tel: 04-2708800, Fax: 04-3377178

Please complete clearly (All fields are mandatory)

FORM No:

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		
Date of Service:	Patient's Tel:	**DOB**	**Sex:** • F • M
Emirates ID No:		Email address: *(Mandatory)*	

SUBJECTIVE ***(To be completed by Physician)***

Symptom(s) As Described by Patient *(CHIEF COMPLAINT)*
Date of Present Symptom Onset: ______ / ________ / ________ (dd / mm / yyyy)
What date did the Patient first feel same / similar symptom(s): ______ / ________ / ________ (dd / mm / yyyy)
Is the Patient under any type of treatment / Meds: •YES • NO *If yes, indicate what assessment and since when:*
OBJECTIVE / ASSESSMENT ***(To be completed by Physician)*** **T: P: R: B/P:**
Past Medical & Surgical History:
Clinical Details & Description of Present Case:
Cause: •Physical Illness •Accident •Maternity •Preventive •Psychiatric •Dental •Work Related •Other •Acute •Chronic •Confirmed •Suspected

Assessment / Diagnosis: INDICATE DIAGNOSIS NOT SYMPTOM	**Diagnosis Code**
1.	
2.	
3.	

Is Assessment / Diagnosis related to another Assessment? • YES • NO *If yes, specify: (i.e. Retinopathy related **to** Diabetes*

MEDICAL PLAN

• **Consultation**	*Cost*	• **Physiotherapy**	*Cost*
• **Pharmacy**	*Cost*	• **Laboratory / Radiology / Other**	*Cost*
TOTAL CHARGES			

Was In-patient Required? Length of Stay__________________________ **Indicate Provider**__________________________ **Cost** ____________

- ***Discharge Summary: Itemized Invoices, Reports & Receipts Attached?***

Treating Physician Name:	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to NEXtCARE for the purpose of determining insurance benefits.*	
Name & Address of Facility:		
Tel / Fax:		
Email:		
Signature & Stamp:	*Patient's Signature (Parent if minor)*	*Date*

BANK DETAILS **(To be completed by cardholders for Wire Transfer transactions within UAE only)**

Account name	
Bank name	
Branch	
Account number	
Currency	
IBAN number	
Swift Code	

Documents required for reimbursement claims **(All the provided documents should be in English or Arabic only):**

- Duly filled and stamped reimbursement form.
- Copy of your health Insurance card.
- Original itemized bill with service date.
- Original prescribed medicine by your treating physician.
- Investigation/Diagnostic tests' results and reports.
- For Hospitalization cases, a duly signed and stamped discharge medical report is required.
- Original receipts for claimed amount.
- Copy of police report (For Accident Claims).
- For Treatment outside UAE, copies of your passport showing the exact date of exit and entry stamps proving your period of stay outside U.A.E.

For any assistance, please contact:

- **NEXtCARE** (24/7):
  Telephone: +971 (4) - 2708800
  Fax: +971 (4) - 3377178

- **MEDGULF** (Sunday through Thursday – 8 AM till 5 PM)**:**
  Telephone: +971 (4) – 3738888
  Toll Free Number: 800 (MEDGULF) – 800 (6334853)