NGI
الوطنية للتأمينات العامة
NATIONAL GENERAL INSURANCE

Form No : ZH 74502

REIMBURSEMENT FORM FOR OUT OF NETWORK TREATEMENT

SECTION - A: POLICYHOLDER'S DETAILS (TO BE COMPLETE BY THE INSURED)

Health Policy / Card No :		
Name Of The Policy Holder :	**Date Of Birth :**	**Sex :**
Name Of The Employee (If Different From Policy Holder) :		
Patient's Relationship To Insured : Self Spouse Dependent Child	☐ **Self** ☐ **Spouse** ☐ **Dependent Child**	
Contact Number : (Mobile)	**Other :**	
E-Mail Address :		
Total Claim Amount (In Original Currency) :		

DECLARATION / AUTHORIZATION :

I certify that all information contained in / provided with the claim form is complete and correct. I hereby authorized any doctor, hospital, clinic or medical provider, any insurance company or any other organization or person who has medical record or information about me and / or of my family members (if covered under HealthNet Insurance Policy) to furnish it to National General Insurance Co. (PSC). Any photocopy of this declaration / authorization shall be deemed as effective as the original.

Signature Of The Policy Holder
(Self & On Behalf Of Family Member)

DATE :

Signature & Seal Of The Employer / Sponsor
(Optional For Group Scheme Only)

DATE :

SECTION B: PATIENT DETAILS (TO BE COMPLETED BY TREATING DOCTOR)

Name Of The Patient :	**Date Of Birth :**	**Sex :**
Name Of Treating Physician / Surgeon :	**Specialty :**	
License / Registration No :		
Name & Address Of Hospital / Clinic :		
Telephone No :	**E-Mail Address :**	
Are You The Patients Primary Physician? ☐ **Yes** ☐ **No**		
Presenting Complaints :		
Duration Of Symptoms :		
Onset Of Condition :		
Relevant Past Medical / Surgical History :		
Diagnosis :	**ICD Code :**	
Etiology :		

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PLAN DETAILS OF MANAGEMENT

Procedure :	**Cpt Code :**
Laboratory Test :	
Radiology / Investigations :	

INCASE OF HOSPITALIZATION

Date Of Admission :	**Date Of Discharge :**

SECTION C: FOR OFFICE USE ONLY (TO BE COMPLETE BY CLAIMS MANAGER)

Remarks :

Claims Manager Signature

DATE :

Authorized Signatory's Signature

DATE :

INSTRUCTIONS

Please read the following information before filling the form. Please fill section A of this form and request your doctor to fill up Section B. Please attach the following supporting documents to your claim form:

1) Original Itemized Bills / Invoices
2) Original Payment Recipts / Credit Card Slips
3) Original Prescriptions
4) Original Discharge Summary
5) Copies of Laboratory and Radiology Report
6) Copies of Operative Notes and Histopathology Report In case of Surgery
7) Copy of Birth Cirtificate in case of Child Birth
8) Copy of Pre-authorization Letter form HealthNet
9) Legal translation of all document in case original are in any other language other than Arabic and English

Reimbursement claims within UAE to be submitted 30 days and if outside UAE to be submitted within 90 days of treatment date. In case documentation is not provided, the claim should be completed within 30 days after rejection will be deemed final.

If you have any difficulty filling this form, please contact our Customer Services Desk during office hour (08:30 am to 05:00 pm except Friday & Saturday)
Telephone: +971 4 2115 800 or Email: customerservice@ngiuae.com

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