



## Documents Needed For Reimbursement Claims

### Documents Needed For Doctor Visit, Ambulatory Tests And Hospitalization Reimbursement Claims

1. Detailed Medical Report signed and stamped by the treating physician (Diagnosis, complaints, past medical history, duration of illness and other conditions).
2. Detailed original invoice i.e. cost per item.
3. Results for all tests done e.g. labs, radiology, cytopathology... etc.
4. Discharge summary for in-patient cases.

### المستندات المطلوبة لإعادة تسديد زيارة الطبيب والفحوصات الخارجية وحالات الاستشفاء داخل المستشفى

1. تقرير طبي مفصل موقع ومختوم من قبل الطبيب المعالج يشرح وضع المريض الصحي (التشخيص، شكوى المريض، بداية ظهور الاعراض او الحالة المرضية، التاريخ المرضي السابق و اي حالات اخرى).
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.
3. نتائج التحاليل المخبرية والاشعة وتحاليل الانسجة ( الباثولوجيا الخلوية ) ... الخ.
4. التقرير النهائي عند خروج المريض من المستشفى ( فقط في حالة الاقامة داخل المستشفى للحالات المرضية او الجراحية).

### Documents Needed for Prescription Medicine Reimbursement Claims

1. Original prescription or a stamped copy of the prescription in case the prescribed medicines are antibiotics or steroids.
2. Detailed original invoice i.e. cost per item.

### المستندات المطلوبة لإعادة تسديد الأدوية موضوع وصفة طبية

1. الوصفة الأصلية أو صورة مختومة بخاتم الصيدلية في حالة وصفات المضادات الحيوية ومركبات الكورتيزول.
2. فاتورة اصلية مفصلة محدد فيها سعر كل دواء.

### Documents Needed for Dental Treatment Reimbursement Claims

1. Panoramic X-ray.
2. Detailed original invoice i.e. cost per item.

### المستندات المطلوبة لإعادة تسديد علاج الاسنان

1. الأشعة السنية (Panoramic).
2. فاتورة اصلية مفصلة محدد فيها سعر كل خدمة مقدمة.

A copy of the insurance card and the Civil ID should be enclosed.

يجب ان يرفق مع كل طلب صورة عن بطاقة التأمين والبطاقة المدنية.

## Payment Details

Have you personally had to pay costs for the treatment that you are claiming for?  Yes  No  
If yes, and you are personally seeking reimbursement, please tell us how you wish to be reimbursed (Please tick one):

1.  **Bank Transfer.** Please fill in this information for bank transfer payments: (Please note that this is the quickest and safest method of payment)

Name of Account Holder	
Name of Your Bank	Account Number
Address For Your Bank	
Iban Number	
Routing Code / Swift Code / Sort Code	Currency of Bank Account

2.  **Foreign Draft.** Please tell us what currency

## Member's Declaration

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by Insurance Company/ GlobeMed. I confirm and agree that any personal information collected or held by Insurance Company/GlobeMed, whether given on this form or collected in any other way, may be used by Insurance Company/GlobeMed or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving on-going insurance cover, customer service and the processing of future claims, ii) processing and making payments, iii) providing marketing communications in respect of Insurance Company/GlobeMed, its related products and services and those of its associated companies.

Member's Signature

Date (dd/mm/yy)