دبي للتأمين
DUBAI INSURANCE

DubaiCare

REIMBURSEMENT FORM

Patient's Name:			
Healthcare Provider:	**Telephone no:**		
Date of service:	**DOB:**	**SEX:**	**M F**
Membership Number (compulsory)			

Medical Section

Symptoms & Diagnosis

Details of Physical findings

Details of investigations done

Details of treatment done

Itemised original Receipts and applicable prescriptions /reports/results must be enclosed to consider the claim.

Medical Practitioner's Name & Address:	**Tel:**
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.	
Signature and Stamp of the Medical Practitioner	**Date:**

Patient's declaration & consent
I confirm that I am the patient/ patient's parent or guardian and wish to claim benefits, and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to DubaiCare. I agree that a copy of this consent shall have the validity of the original.
Signature of the Patient **Date:**

DubaiCare, P.O. Box 3027 Dubai – UAE Toll Free: 800 3 82467.

For any enquiry please call from 08.00 am to 17.00 pm (Sunday to Thursday)

For Bank transfers, please furnish below details

Beneficiary Name:
Beneficiary Address:
Account No:
IBAN No:
Swift Code
Bank Name
Branch Name