Reimbursement Claim Form

If you have any questions regarding this form or any other aspects of your cover, please telephone **NAS** (+9712 6940800) or Toll Free 800 2311

Details of member / patient

Employee Name	Your Insurance Card No
Patient's name and address	Employee No / Staff ID No:
Company Name	Date of birth / /
Employee's Email address	Employee's Tel number
Nationality	

Medical section (To be fully completed by patient's medical practitioner – all boxes must be completed in block capitals.)

Physician's name and address	Date symptoms first noticed
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.	Physician's Signature and stamp Date / /

Diagnosis

Other insurer's details (If the treatment is accident-related or covered under another insurance policy please provide name of insurance company.)

Patient Section

Out Patient Treatment	Claimed Amount	In Patient Treatment	Claimed Amount
Consultation		Hospital charges/ Room	
Pharmacy		Surgery / Anesthesia / OT	
Diagnostic / Lab / Others		Drugs / Labs / Others	
Country of Treatment			
Total Claimed Amount and Claimed Currency			

Patient's declaration and consent

I confirm I am the patient / patient's spouse or guardian (if patient under 16 years of age) 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 authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to NAS. I agree that a copy of this consent shall have the validity of the original.

Signature

Date / /