

Reimbursement Claim Form



Please read the instructions and guidelines on Page 2 before filling this form.

1. Card Holder's Identity and Contact Information									
Name:* (Exactly as printed on the Daman card)									
Daman Card No.:					Mobile No.:				
E-mail Address:*									
2. Claims Payment Details									
Wire Transfer (Please provide the bank account details to which Daman should transfer the money entitle under this reimbursement claim.) If the IBAN number provided herein is incorrect, Daman shall not be liable for any direct/indirect/consequential results from the wire transfer to such number.									
Beneficiary Name:									
Bank Name:					Branch, Bank Address:				
Account Number:					Swift Code Number (For International Transfers)				
IBAN									
I authorise the National Health Insurance Company - Daman PJSC ("Daman") to make wire transfer payment against this Reimbursement Claim Form and hereby discharge Daman from any liability with respect of releasing the payment to the bank details as specified by me hereinabove.									
3. Information on Road Traffic Accident, Work Related, Third Party Liability and Double Insurance (Refer to General Instructions)									
Treatment cause is Road Traffic Accident (RTA): <input type="checkbox"/> No <input type="checkbox"/> Yes									
Treatment cause is work related: <input type="checkbox"/> No <input type="checkbox"/> Yes									
Treatment cause is other than the above specified, wherein a third party is involved: <input type="checkbox"/> No <input type="checkbox"/> Yes									
Reimbursement claim is covered by other insurance policy: <input type="checkbox"/> No <input type="checkbox"/> Yes; Please specify									
4. Medical Information (To be filled-in by the treating practitioner who is licensed by the competent authority of the concerned country)									
Visit Date:									
Medical History/Chief Complaints:									
Diagnosis:									
Treatment Details:									
Currency (If treatment availed outside UAE):					Total Amount Paid:				
I declare that I have attended to this patient and that the particulars given are true and correct to the best of my knowledge.									
Name (Medical Practitioner)		Signature			Date		Stamp		
5. Authorisation									
I, hereby authorise Daman to have access to and take copies of all my files and records at any time relating to any healthcare services provided to me during the period of my insurance coverage with Daman. This authorisation is valid at any healthcare provider, including but not limited to hospitals, medical centres, clinics, laboratories, diagnostic centres, rehabilitation centres and pharmacies. I understand that from time to time Daman may need to disclose this information to third parties for reasons related to insurance including but not limited to the processing of my claim, research/statistical purposes, or to prevent/control fraudulent or improper claims etc. Furthermore, I hereby authorise Mr. /Ms. /Company..... to receive medical information related to this claim from Daman on my behalf.									
6. Declaration									
I hereby declare that I am the patient/patient's legal guardian (if the patient is under 18 years of old). (Please cross out if not applicable). I, the undersigned, hereby represent that the information provided above is correct and that the reimbursement requested is for the costs and expenses paid by me for the treatment of my covered condition. I understand that it is unlawful to provide false, incomplete and/or misleading facts and information (misrepresentation) to Daman for the purpose to defraud or attempt to defraud Daman. I further understand that such act may lead to imprisonment, fines, denial of coverage, loss of benefits and legal damages.									
Name of Card Holder/ Legal Guardian/ Legal Representative					Signature			Date	

General Instructions

- Please note that all information related to this Claim is strictly confidential and shall not be disclosed by Daman to any third party, unless such disclosure is made pursuant to the relevant laws and regulations or authorised by you under Section 6.
- This form can be used for all types of Daman medical plans and has to be completed by the Card Holder if direct billing facility is not available at the healthcare provider.
- In the event that a third party is filling in and submitting this Reimbursement Claim Form on your behalf, please provide a copy of authorised person's passport or emirates ID to Daman.
- Use separate form for each insured member.
- Please read the form carefully and make sure to complete all information and attach all essential documents as specified herein otherwise Daman will not be able to process your Reimbursement Claim.**

Essential Documents:	<ul style="list-style-type: none"> Original itemised bill / invoices with date. Proof of payment (Paid stamp on invoice, original receipt, credit cards payment receipt, etc.). Original prescription for medication given by the medical practitioner. Original authorisation letter and copy of identity document of the authorised person if this Reimbursement Claim Form is completed and submitted by a third party. Copy of identity document of the authorised person for collection of payment and/or information from Daman. Copy of visa page if the Card Holder is a minor. The following documents are required as below: <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Cases</th> <th>Road traffic accident</th> <th>Work related treatment</th> <th>Any other third party liability</th> </tr> </thead> <tbody> <tr> <td>Police report</td> <td>✓</td> <td>✓</td> <td>✓</td> </tr> <tr> <td>Subrogation letter</td> <td>✓</td> <td>✓</td> <td></td> </tr> <tr> <td>Relevant insurance policy</td> <td>✓</td> <td>✓</td> <td>✓</td> </tr> <tr> <td>Court judgment</td> <td>✓</td> <td>✓</td> <td>✓</td> </tr> </tbody> </table> <ul style="list-style-type: none"> If reimbursement claim is covered by other insurance policy, a copy of relevant policy is required 	Cases	Road traffic accident	Work related treatment	Any other third party liability	Police report	✓	✓	✓	Subrogation letter	✓	✓		Relevant insurance policy	✓	✓	✓	Court judgment	✓	✓	✓
Cases	Road traffic accident	Work related treatment	Any other third party liability																		
Police report	✓	✓	✓																		
Subrogation letter	✓	✓																			
Relevant insurance policy	✓	✓	✓																		
Court judgment	✓	✓	✓																		
Additional Requirements for Inpatient and Day Care (Hospitalisation Cases):	Original Medical Report and/or Discharge Summary stamped and signed by the treating medical practitioner and health care provider.																				

Note:

- The Card Holder shall keep with him/her copy of original receipts and documents enclosed with the reimbursement claim as Daman will not return the original documents submitted to it unless there is a complete denial of your claim.
 - Daman may require reviewing the original diagnostic investigation results/reports (such as Radiology and Laboratory investigation services) for services costing above **AED 1000** for any medical clarifications. Therefore, kindly ensure that the original documents are kept securely. Daman reserves the right to reject any claims if original documents are not available upon request.
 - In case of treatment availed outside the UAE, Daman reserves the right to ask for a copy of passport page with the entry and exit stamps and a valid visa page or any other document proving your stay outside the UAE.
- Wire transfer information:
 - The wire transfer payment will be deposited in the account number mentioned in this Reimbursement Claim Form.
 - Wire Transfer payment fee will be paid by Daman. Any other amount charged by the bank to the Card Holder for this service and/or any taxes levied shall not be the responsibility of Daman.
 - Daman will inform the card holder about the status of the reimbursement claim within **10 working** days from the claim received date.
 - All invoices subject to reimbursement should be submitted to Daman **within 180 Days** (counting from the last treatment date) based on the coverage offered for respective Daman Health Insurance Plans.
 - Daman is accepting claims submitted in the following languages: **English, Arabic, Dutch, French, Russian, Hindi, Urdu, and German** (which might take additional five days for non-Arabic and non-English claims to be processed). Claims submitted in languages other than the above listed should require translation to English or Arabic by certified translator licensed in the UAE (additional time for claims submitted with translation may be required to be processed).
 - For any claim with foreign currency, Daman will consider the exchange rate on the day of processing the claim based on the prevailing exchange rate on that day.

If you have any questions or need help completing the claim form, please contact allocated numbers to each insurance plan as follows

For Essential Benefits Plan call +971 2 6145454

For Other Health Insurance Plans call 800 4 32626 within the UAE or +971 2 6149555 outside UAE.