Reimbursement
Claim Form

Administrative section

Please keep all original documents and records until your claim is settled. Reimbursements will be processed in the currency your policy has been set-up in. All dependent claim reports will be directed to the contact details provided by the main member. A copy of these reports will also be sent to the main member as per the contact details provided by the Corporate Client.

Policy number:	Membership number:
Patient name:	Provider name:
Date of treatment:	Patient gender:
Mobile number:	Email address:

Medical section

Type of visit: ☐ Outpatient ☐ Inpatient ☐ Emergency ☐ Maternity ☐ Dental ☐ Optical

If pregnant, LMP (last menstrual period) date:	Nature of conception:

Chief complaint:

History of present illness (please include duration, date of onset, and when the patient became aware of each condition):

Clinical findings/other conditions:

Past medical history:

Details of trauma - if applicable (when, where and how)

☐ Work related ☐ RTA related (include a police report) ☐ Sports related

If yes:
☐ professional
☐ non-professional

Diagnosis:

Treatment plan, recommended medications, investigations, and/or procedures:

Patient declaration

I hereby confirm that I am the patient/AXA card holder, patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/information given above are to the best of my knowledge true and correct. I hereby consent to and fuly authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C.(c) representative or any of AXA's affiliates. I subrogate all my rights in relation to this claim and I fully authorise and give access to AXA Insurance (Gulf) B.S.C.(c) representative or any of AXA's affiliates to audit, review, and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.

Medical practitioner declaration

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.

Name:

Date:

Signature Stamp

Signature: Date:

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits/cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +97 4 412 8733, Bahrain +973 (17) 582 612, Oman +968 800 70292, KSA +966 (1) 478 0282 quoting the policy and membership numbers. Claims must be submitted along with supporting documents within 90 days from date of service. Send this claim form together with the supporting material to Medical Department, AXA Insurance, P.O. BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain, AXA Insurance P.O. Box 1276, P.C. 112, Ruwi, Sultanate of Oman or AXA Insurance P.O. Box 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, P.O. Box 15319, Doha, State of Qatar.