24/7 Hotline: 600 532273

Email: rc@ecaretpa.com

REIMBURSEMENT CLAIM FORM

All fields to be filled completely & clearly

Patient Details

Member's Name		UB/Card No
DOB (dd/mm/yyyy)	Mob/Tel No	Email Address
Principal's Name		Employer's Name
Policy Start Date	End Date	Insurance Company

Medical Details (to be filled by physician)

Date of Treatment	If hospitalized, date of admission	Date of discharge
Patient's chief complaints & symptoms		
Date of Present Symptom Onset (dd /mm /yyyy)	Date the patient first feel same/similar symptoms (dd /mm /yyyy)	
Past Medical & Surgical History		

Diagnosis (Primary & Secondary)	Diagnosis Code
1.	
2.	
3.	

Investigation/Radiology	Prescription

Is the case related to: Road & traffic accident? ☐Yes ☐No	Work-related? ☐Yes ☐No	Emergency? ☐Yes ☐No
If any of the above applies, please provide complete details.		

Reason for not using in-network facilities

☐ Emergency ☐ Service not available ☐ Outside UAE Treatment ☐ Others (specify):

Claimed Invoices

No.	Invoice No.	Invoice Date	Service Item	Provider Name	Amount	Currency	Cost in AED
1							
2							
3							
4							
5							

Settlement Details

Bank Account Holder's Name	UAE IBAN No
Account No	UAE Swift Code
Bank Name & Address	

Medical Practitioner Declaration

I, the undersigned, hereby declare that all information provided is correct, and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Treating Physician Name
Name & Address of Facility
Tel/Fax/Email
Signature & Stamp

Patient Declaration

I, the undersigned, hereby declare that the information above is true & complete. I hereby authorize any healthcare provider, insurer, employer or other organization to release any information regarding my medical condition & history to Ecare International for the purpose of determining insurance benefits.

Patient's signature (Parent if minor)	Date

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Email: rc@ecaretpa.com

REIMBURSEMENT CHECKLIST

- ☐ Completely filled claim form (signature & stamp of treating physician is mandatory)
- ☐ Insurance card copy
- ☐ Official itemized invoices with specified service details/bill breakdown
- ☐ Proof of payment
- ☐ Prior approval or 24-hour case notification email copy for IP, day case or emergency treatment
- ☐ Discharge summary with the operative notes (for surgical treatment) for IP, day case or emergency admissions
- ☐ Prescription copy for all medications
- ☐ Laboratory and imaging/radiology test reports
- ☐ Medical report with injury details (when, where and how the injury happened), punch log details with official duty roster from HR for claims related to any kind of injuries.
- ☐ Referral letter from specialist consultant and progress reports (after every 5 sessions) for claims related to physiotherapy treatment/ chiropractic treatment
- ☐ Exit and entry stamp copy for treatments done outside of UAE
- ☐ Police report in case of accident (if covered under medical policy)

Note:

- Ecare International, if required, may request for additional documents to further process the claim.
- Incomplete submission of documents may result in delay of the claim evaluation process. Please ensure that all details in the documents are clear.
- All documents must be in English language. Please provide official translation if claim was done outside of UAE.

Claim submission:

Send your claim documents to rc@ecaretpa.com with the member's name (as printed on the card) & UB/card number as the subject line of your email. Please note that members have 15 days to appeal claims decision.