

CLAIM FORM – MEDICAL REIMBURSEMENT



IMPORTANT NOTE: Please read the instructions & guidelines on overleaf before filling the form.

| | |
|----------------|--------------|
| Member's Name: | Card Number: |
| Company Name: | Emirates ID: |

Reason for utilizing reimbursement:

Within Network
 Non-network
 Referred by TPA
 Emergency
 Outside UAE

Others please specify

Medical plan:

| Facility Name | Encounter Date | Service description | Amount in AED |
|---------------|----------------|---------------------|---------------|
| | | | |
| | | | |
| | | | |
| | | | |

Currency (if treatment availed outside UAE)..... **TOTAL:**

Duration of Hospitalization stay: (For IP cases only):

| | |
|--------------------|--------------------|
| Date of Admission: | Date of Discharge: |
|--------------------|--------------------|

Information on Road Traffic Accident, Work related. (Refer to general policy instructions).

Treatment cause is Road Traffic Accident? NO YES (Please specify).....

Treatment cause is work related? NO YES (Please specify).....

For Documentation:

| | |
|--|---|
| Prior approval obtained? | <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, please attach email copy/reference number with date). |
| Courier/ Messenger (If courier Please specify AWB No). | |

For office (Lifeline TPA) Use only:

| | |
|------------------------------------|-------------------|
| Claim received at Lifeline TPA on: | Reference Number: |
| Reimbursement Claim ID: | Claim Status: |

HELPLINE: 600 54 33 26

T: +971 6 523 4478 F: +971 6 523 4809 P.O. Box: 79363, Sharjah - U.A.E





PROCEDURES & DOCUMENTS REQUIRED:

1. Always write your name & medical insurance card number as cited in the card
2. Referral letter /Referral email/Reference approval number for all elective cases must be enclosed with the claim form or else the claim will not be considered for processing.
3. Intimation mail copy / Claim reference number is compulsory. Must submit within 24 hours after date of admission /date of service.
4. Copy of passport showing Exit & Re-Entry to UAE if treatment done outside UAE.
5. **Claim Submission Period.** (FROM THE DATE OF DISCHARGE)
 - Within 30days for In-patient if service taken within UAE. (As per the policy terms and conditions).
 - Within 40days if service taken outside the UAE for IP treatment. (As per the policy terms).
 - Within 15days if service taken inside UAE for outpatient at network/non – network clinics. Subject to terms and conditions.
6. **Repatriation:** OP/ IP/ Natural/ Group Life claims should be submit within 30 calendar days.
 - Death Certificate, ID Proof of beneficiary(Passport),Medical Certificate, Police report, Postmortem report in unusual deaths, and Cremation certificate should be attached with the reimbursement form.
7. Original documents should be submitted all the times for processing the claims including invoices, medical reports and Doctors Prescriptions.
8. Documents in the other languages must be translated into English by official public translator prior to submission.
9. Medical reports / discharge summary stamped & signed by the treating doctor.
10. For reimbursement related queries kindly email as only at:
 - approval@lifelinetpa.com
 - helpdesk@lifelinetpa.com
11. Submit all the original reimbursement documents to:
Office 303, Fatima Bin Abdulla Owais Building,
Building No. 2546. Same building of Lifestyle Gym,
Maliha Road, Near National Paints and Al Madina Hypermarket.
PO. Box: 79363. Muwaileh, Sharjah.
12. **MODE OF SETTLEMENT:** Business to Business (B2B) transfer only.

Fill the below authorization form for cheque transfer:

AUTHORIZATION FORM FOR CHEQUE TRANSFER

I undersigned, hereby authorize Lifeline TPA to transfer the amount of my claim under this form to the following bank account.

Bank Name: Client name:.....
IBAN number: Account No:.....
Email ID: Mobile Number:

13. Patient declaration:

I declare that I am the patient I hereby represent that the information provided above is correct and are to the best of my knowledge and the reimbursement requested is for the costs and expenses paid by me for the treatment of my covered condition. With this I authorize Lifeline TPA to approach any doctor / medical facility /any institution who has any medical record information about me or my family to furnish it to Lifeline TPA. And I perceive the complete reimbursement form before endorsed.

Signature:..... /...../..... Place:.....
DD MM CCYY

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