WorldCare claim form

Important information:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).
For all **Out-Patient Treatment** and if the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) for **In-Patient** or **Day-Patient Treatment** is less than USD 500 **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to MEAService@now-health.com or fax it to +971 (0) 4450 1430. Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for **Day-Patient** and **In-Patient** (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/discharge reports and email them to MEAService@now-health.com or fax them to +971 (0)4450 1430. Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

If **You** have any questions about this form or any other aspect of your cover, please call us on +971 (0) 4450 1410 or email us at MEAService@now-health.com.

Section 1: Member and Patient Information:

Planholder's name:	**Plan** number:
Patient's name:	Membership number:
Date of birth (dd/mm/yyyy): / /	
Email address:	Telephone number:
Reason for doctor visit/diagnosis: – specify symptoms or medical problem e.g. abdominal pain/rash on foot/eye infection	
Country where **Treatment** took place:	**Treatment** date (dd/mm/yyyy): / /
Currency claim incurred in:	Currency you would like your claim reimbursed in:
Total claimed amount:	
Type of service: **Out-Patient** ☐ **Day-Patient** ☐ **In-Patient** ☐ Dental ☐ Maternity ☐ Optical ☐ Routine check-up ☐	
Attending physician: Dentist ☐ **Medical Practitioner** ☐ **Specialist** ☐ Other ☐ Please specify:	
Is this claim due to **Accident**/injury? Yes ☐ No ☐ If yes, include complete medical information. Date of **Accident**/injury (dd/mm/yyyy): / /	

Third party insurers
If some of the costs are recoverable from a third party (for example, if the **Benefits You** are claiming relate to a **Medical Condition** or injury caused by a person or organisation, or if **You** have cover on another insurance policy for this claim), please provide details:

Section 2: Payment details

Please pay: **Planholder** ☐ Provider ☐		
Please choose payment type: Bank transfer ☐ Cheque ☐		
1. Bank transfer – please complete all details to enable bank transfer payments.*		
Account/payee name:	Payment currency:	
Bank name:	Bank code:	Branch code:
Branch address:		
IBAN or account no.	Routing code: (e.g. Swift or sort code)	
Any other relevant information: (e.g. Local bank code)		
2. Cheque**: Payee name		
Cheque mailing address:		
Payee's telephone number:		

* **We** endeavour to ensure that all bank charges are paid by **Us**; however on occasions **You** may incur a charge levied by **Your** own bank, over which **We** have no control.
** If **You** require payment via cheque, please note that this will be sent to **You** in the post, and may take some time to be received.

I have read the declaration in Section 4 on the next page
I agree to the declaration, give my authorisation and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.
I will enclose Section 4 if authorisation has been limited by me where available.

Patient's signature (Insured/main applicant):	**Date** (dd/mm/yyyy):
	/ /

Section 3: Medical information, Day-Patient and In-Patient claims over USD 500

(to be completed by the doctor responsible for the patient's **Treatment**)

Medical Condition:	Diagnosis ICD10 code (if applicable):
Details of any underlying cause:	
When did the patient first see a doctor? (dd/mm/yyyy) / /	
Details of **Treatment**/medication:	
Details of operation (if any):	
	Procedure code (if applicable):
Hospital details (if applicable):	**Treatment** date (dd/mm/yyyy): / /
Name:	
Address:	
Admission date (dd/mm/yyyy): / /	Discharge date (dd/mm/yyyy): / /

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.

Print name:	Official stamp:
Signature:	
Date (dd/mm/yyyy): / /	

If **Your Plan** includes a cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.
Direct Billing: It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on +971 (0) 4450 1410.

Section 4: Declaration

We may contact **You** with details of other products and services which may be of interest to **You. You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box ☐.

Declaration

I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the WorldCare **Plan**.

I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International (Services) FZ LLC, Ground floor, Al Shaiba building, Dubai Outsource Zone, P.O Box 502163, Dubai, UAE.

Plans are underwritten by AXA Insurance (Gulf) B.S.C. (c). Dubai Branch: PO Box 32505, Dubai, UAE.
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Now Health International (Services) FZ LLC administers plans on behalf of AXA Insurance (Gulf) B.S.C. (c), PO Box 502163, Dubai, UAE.

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