WorldCare claim form: Medical Providers

Administered by: NOW HEALTH INTERNATIONAL

Insured by: RSA

Important information for Medical Providers:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within 30 days from the end of the month in which **Treatment** is given, or as per the contractually agreed submission period.

You can scan this claim form, receipts/diagnostic reports/discharge reports and membership card, and email them to MEAService@now-health.com or fax them to +971 (0) 4450 1416.

If you have any questions about this form, please call us on +971 (0) 4450 1415 or email us at MEAService@now-health.com.

Section 1: Member and Patient Information: (to be completed by the patient)

Planholder's name:	
Patient's name:	
Membership number:	Date of birth (dd/mm/yyyy): / /
Gender:	Telephone number:
Medical record number (if available):	

Section 2: Medical Information (to be completed by the doctor responsible for the patient's **Treatment**):

Provider name:		
Provider address:		
Medical Condition:		
Diagnosis ICD 10 code:	**Treatment** date (dd/mm/yyyy): / /	
Type of claim: Illness ☐ Injury ☐ **Accident** ☐		
If the claim is due to an **Accident** and some of the costs are recoverable from a third party (for example a person or organisation involved in the **Accident**), please provide details:		
Type of condition: Acute ☐ Chronic ☐ Maternity ☐ Congenital ☐		
Type of service: **Out-Patient** ☐ **Day-Patient** ☐ **In-Patient** ☐		
For **In-Patient or Day-Patient Treatment**	Admission date (dd/mm/yyyy): / /	Discharge date (dd/mm/yyyy): / /
Treatment/Medication details:		
Date on which the patient first consulted you for this **Medical Condition** (dd/mm/yyyy):	/ /	
Date on which the first onset of symptoms have been apparent to the patient (dd/mm/yyyy):	/ /	
Did the patient receive any **Treatment** in the past for this **Medical Condition**? If yes, please provide details (include medical reports)		
Total claimed amount:	Currency claim incurred in:	

Medical Practitioner Declaration:

I declare that I am the patient's **Medical Practitioner** and that:

1. The particulars given herein are, to the best of my knowledge, true and correct
2. I have applied the conditions detailed in the Provider Agreement and Manual held with Now Health, where applicable; and
3. The **Plan** member's claim detailed herein is covered by their **Plan Benefits** and that if any payment is invalid Underwriters shall be entitled to recover the erroneous payment.

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

Section 3: Patient declaration and authorisation

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 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, rescission 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 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 Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource Zone, PO Box 502163, Dubai, UAE.

I have read the declaration in Section 3.

I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of the **Plan**.

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