NOW HEALTH INTERNATIONAL

WorldCare claim form: Medical Providers

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 GlobalService@now-health.com or fax them to +971 (0)4450 1530.

If you have any questions about this form, please call us on +971 (0)4450 1510 or email us at GlobalService@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): / /	Admission 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 Now Health shall be entitled to recover the erroneous payment.

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

Section 3: Patient declaration and authorisation

Data Privacy

We and **Underwriters** will collect certain information about **You** in the course of considering **Your** claim. This information will be processed for the purposes of administering claims. **Your** information may be passed to **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** for this claim. If **We** need to do this, **You** have specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** claim.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   i) **You** have seen the report and approved it; or
   ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.
   Important note: The sooner We receive the report, the sooner We can deal with Your claim.
3. Having seen the report, **You** can refuse **Your** consent – again this may affect Our ability to deal with **Your** claim.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s)he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let **You** see all reports supplied to **Us** within the last six months.
   Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your Plan.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care.

In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

Important note: We regard the rights above as best practice but the legal requirements may differ in the country in which You reside. Please contact Us for additional information regarding regulations in Your jurisdiction.

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 Now Health International **Plan**.

I have read the statement notifying me of my rights with regards to access to medical reports 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 Limited, PO Box 482055, 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**.

Signature (Insured/main applicant):	**Date** (dd/mm/yyyy):
	/ /