SAICOHEALTH DAMANA

SAICOHEALTH Medical Claim Form

Section A: To be completed by the insured member.	
Patient Details	
Member No.	Employee No.
Birth Date:	Patient Name:
Email Address:	Mobile Number:
Treatment Details	
Country of Treatment:	Date of Treatment:
Date First Seen:	
Breakdown of Expenses (required)	
Currency of Expenses	
Doctor's Fees (Consultation)	
Medicines	
Others (lab, x-rays, dental, vision, etc.)	
Total Amount Claimed	
Reimbursement Details	
Pay to (Beneficiary Name):	
Email Address:	Mobile No:
Currency: *Claims incurred in the United Arab Emirates and submitted by the member to SAICO are only reimbursable in local currency.	
Cheque Payment – provide mailing address below	Deposit to Bank Account – provide bank account details
IBAN (Bank Acct No.)	Bank Name:
Mailing Address (include a contact number for courier delivery):	

Authorization: I the undersigned, hereby certify that all answers and all documents submitted with this Claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me and/or any of my family members to provide SAICO with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

Signature:
Date:

Section B: To be completed by the provider.	
Patient Name (CAPITALS):	Age:
Diagnosis (CAPITALS):	ICD:
Type of Treatment:	
Date of illness (Date first seen: ______________________)	Accident (Date:____________________Time:________) (Cause:________________________________)
Pregnancy (Date of LMP:______________)	Hospitalization: (Date Admitted:______________________) (Date Discharged: ______________________)

PHYSICIAN'S DECLARATION: I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.

Physician's Stamp:______________________________Signature:________________Date: ______________

Section C: Attachments Required

- Invoices with proof of payment.
- Doctor's prescription for medicines, lab tests, x-rays, etc.
- Pharmacy invoice clearly showing name of medicine, quantity purchased, and price of each medicine.
- Copy of patient's SAICOHEALTH ID card.

Section D: Contact Information

Email: customerservice@saicohealth.com

Please reference your SAICO ID card for local phone and fax numbers

SAICO Health Care W.L.L.