

**Please read the instructions and guidelines on Page 3 before filling this form.**

## 1. Card Holder's Identity and Contact Information:

Name: <i>(Exactly as printed on the Daman card)</i>	
Emirates ID No.:	Daman Card No.:
Address:	Mobile No.:
E-Mail Address:	

## 2. Claims Payment Preference

**Wire Transfer** *(Please provide the bank account details to which Daman should transfer the money entitle under this reimbursement claim.)*

Beneficiary Name:															
Bank Name:															
Branch, Bank Address:															
Account Number:															
<b>IBAN</b>															

**Direct Cheque**

### Collection Method

- I will personally collect the cheque from Daman's Branch *(Please specify Daman's Branch location):* \_\_\_\_\_
- Mr./Ms.: \_\_\_\_\_ Emirates ID No.: \_\_\_\_\_ Mobile No.: \_\_\_\_\_ will be collecting the cheque on my behalf.

### Beneficiary Name

- Please issue the Cheque in my name.
- Please issue the Cheque in the name of Mr./Ms./Company: \_\_\_\_\_  
Emirates ID No./Commercial License Number:: \_\_\_\_\_ Mobile No.: \_\_\_\_\_

I authorise that National health Insurance Company – Daman PJSC ("Daman") to release and/or issue the cheque related to this Reimbursement Claim Form to the person hereinabove and hereby discharge Daman from any liability with respect of releasing the payment and/or issuing the Cheque as per the method and beneficiary name specified by me hereinabove.

## 3. Medical Information *(To be filled-in by the treating practitioner who is licensed by the competent authority of the concerned country)*

Visit Date: \_\_\_\_\_

Medical History/Chief Complaints:

Diagnosis:

- Is the above case related to a Road Traffic Accident?  No  Yes
- Is the above case work related?  No  Yes
- Is the above case related to any third party liability other than the causes specified above?  No  Yes; please specify: \_\_\_\_\_

Treatment Details:

**I declare that I have attended to this patient and that the particulars given are true and correct to the best of my knowledge.**

\_\_\_\_\_  
Name *(Medical Practitioner)*                      Signature                      Date                      Stamp

## 4. Information on Road Traffic Accident, Work Related, Third Party Liability and Double Insurance (Refer to Appendix A – General Instructions)

Treatment cause is Road Traffic Accident (RTA):

No  Yes

Treatment cause is work related:

No  Yes

Treatment cause is other than the above specified, wherein a third party is involved:

No  Yes

Reimbursement claim is covered by other insurance policy:

No  Yes; please specify: \_\_\_\_\_

## 5. Claim Information (Refer to Appendix A – General Instructions)

**Reason for not using your respective plan's network of medical services providers**

Emergency  Family Doctor  Personal Choice  Service Not Available  On Vacation/Business Trip Outside UAE

Others; please specify: \_\_\_\_\_

Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount

**Currency (If treatment availed outside UAE):** \_\_\_\_\_ **Total:** \_\_\_\_\_

## 6. Authorisation

I, hereby authorise Daman to have access to and take copies of all my files and records at any time relating to any healthcare services provided to me during the period of my insurance coverage with Daman. This authorisation is valid at any healthcare provider, including but not limited to hospitals, medical centres, clinics, laboratories, diagnostic centres, rehabilitation centres and pharmacies.

I understand that from time to time Daman may need to disclose this information to third parties for reasons related to insurance including but not limited to the processing of my claim, research/statistical purposes, or to prevent/control fraudulent or improper claims etc.

Furthermore, I hereby authorise Mr./Ms./Company \_\_\_\_\_ to receive medical information related to this claim from Daman on my behalf.

## 7. Declaration

I, the undersigned, hereby represent that the information provided above is correct and that the reimbursement requested is for the costs and expenses paid by me for the treatment of my covered condition

I hereby declare that I am the patient/patient's legal guardian (if the patient is under 18 years of old). (Please cross out if not applicable).

I understand that it is unlawful to provide false, incomplete and/or misleading facts and information (misrepresentation) to Daman for the purpose to defraud or attempt to defraud Daman. I further understand that such act may lead to imprisonment, fines, denial of coverage, loss of benefits and legal damages.

\_\_\_\_\_  
Name of Card Holder/ Legal Guardian/ Legal Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Appendix A: General Instructions

1. All the sections except section no.3 shall be filled in by the Card Holder and section no.3 shall be filled in by the treating medical practitioner.
2. Please note that all information related to this Claim is strictly confidential and shall not be disclosed by Daman to any third party, unless such disclosure is made pursuant to the relevant laws and regulations or authorised by you under Section 6.
3. This form can be used for all types of Daman medical plans and has to be completed by the Card Holder if direct billing facility is not available at the healthcare provider.
4. In the event that a third party is filling in and submitting this Reimbursement Claim Form on your behalf, please provide a duly signed letter authorising the filling in and submission. A copy of authorised person's passport or emirates ID shall be provided to Daman.
5. In the event that the reimbursement cheque is collected by the authorised person specified under Section 2, the Card Holder shall provide an authorisation letter to the said authorised person to issue a Claim Discharge Receipt and Subrogation Letter.
6. Use separate form for each insured member.
7. **Please read the form carefully and make sure to complete all information and attach all essential documents as specified herein otherwise Daman will not be able to process your Claim Reimbursement Form:**

<b>Essential Documents:</b>	<ul style="list-style-type: none"> <li>• Copy of your Daman Member Card.</li> <li>• Copy of Card Holder's Emirates ID/Passport.</li> <li>• Original itemised bill / invoices with date.</li> <li>• Proof of payment (Paid stamp on invoice, original receipt, credit cards payment receipt, etc.).</li> <li>• Original prescription for medication given by the medical practitioner.</li> <li>• Original authorisation letter and copy of identity document of the authorised person if this Claim Reimbursement Form is completed and submitted by a third party.</li> <li>• Copy of identity document of the authorised person for collection of payment and/or information from Daman.</li> <li>• Copy of visa page if the Card Holder is a minor.</li> <li>• For road traffic accident: (a) police report (copy) (b) subrogation letter (original) (c) relevant motor vehicle insurance policy (copy) (d) court judgment.</li> <li>• For work related treatment: (a) police report (copy) (b) subrogation letter (original) (c) relevant insurance policy (copy) (d) court judgment (copy) (if exists).</li> <li>• For any other third party liability: (a) police report (copy) (b) court judgment (copy) (if exists) (c) relevant insurance policy.</li> <li>• If reimbursement claim is covered by other insurance policy (a) relevant insurance policy (copy).</li> </ul>
<b>Additional Requirements for Inpatient and Day Care (Hospitalisation Cases):</b>	Original Medical Report and/or Discharge Summary stamped and signed by the treating medical practitioner and health care provider.

### Note:

- The Card Holder shall keep with him/her copy of original receipts and documents enclosed with the reimbursement claim as Daman will not return the original documents submitted to it unless there is a complete denial of your claim.
  - Daman may require to review the original diagnostic investigation results/reports (such as Radiology and Laboratory investigation services) for services costing below AED 1000 for any medical clarifications. Therefore, kindly ensure that the original documents are kept securely. Daman reserves the right to reject any claims if original documents are not available upon request.
  - In case of treatment availed outside the UAE, Daman reserves the right to ask for a copy of passport page with the entry and exit stamps or any other document proving your stay outside the UAE.
8. Wire transfer information:
- The wire transfer payment will be deposited in the account number mentioned in this Reimbursement Claim Form.
  - Wire Transfer payment fee will be paid by Daman. Any other amount charged by the bank to the Card Holder for this service and/or any tax/taxes levied shall not be the responsibility of Daman.

9. If the reimbursement cheque is not collected within 6 months from the notification date that the cheque is ready for collection, the Card Holder/beneficiary will forfeit his/her right to claim the money from Daman.
10. If the IBAN number provided herein is incorrect, Daman shall not be liable for any direct/indirect/consequential results from the wire transfer to such number.
11. Daman will inform the card holder about the status of the reimbursement claim within 15 working days from the claim received date.
12. All claims subject to reimbursement should be submitted to Daman from the last treatment dates as mentioned below:
  - a) Within 180 Days for services taken inside and outside the UAE for Premier and CoGenio Plans.
  - b) Within 30 Days for services taken inside UAE for Basic (Abu Dhabi) Plan.
  - c) Within 120 Days for other Daman Health Insurance Plans based on the coverage offered for respective plan.
13. Daman is accepting claims submitted in the following languages: English, Arabic, Dutch, French, Russian, Hindi, Urdu, and German (which might take additional five days for non-Arabic and non-English claims). Claims submitted in languages other than the above listed should require translation to English or Arabic by certified translator licensed in the UAE (additional time exceeding five days stated for permitted languages listed herein may be required for unlisted languages).
14. For any claim with foreign currency, Daman will consider the exchange rate on the day of processing the claim using the prevailing exchange rate.
15. For health insurance plans other than CoGenio, members can submit their reimbursement claims across any of the Daman branches and to the below mentioned postal address. Members under CoGenio Plans, please submit your reimbursement claims **only to** the following postal address:

**Claims Receiving Unit,  
National Health Insurance Company – Daman PJSC,  
Al Bateen, Tower C4, Bainuna Street,  
PO Box – 128888,  
Abu Dhabi, United Arab Emirates.  
Contact Number: +9712 6145622**

If you have any question or need assistance in filling this form,

**For Essential Benefits Plan** call +971 2 6145454

**For CoGenio Plans** call +9712 6145622

**For Other Health Insurance Plans** call 800 4 32626 within the UAE **or** +971 2 6149555 outside UAE