To be Completed by You
To be Completed by your Doctor

REIMBURSEMENT CLAIM FORM

شركة عمان للتأمين (ش.م.ع.)
Oman Insurance Company (P.S.C.)

- Please write in BLOCK LETTERS, complete in full, and submit within 30 days to ensure timely processing.
- For the required supporting documentation; use the attached Summary Table as cover sheet.
- Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections.
- One Claim Form Per Person, Family members must apply Individually.

1. MEMBER AND PAYMENT DETAILS

FORM NUMBER: R I 58616551

Claimant Name		Employer	
Policy Number		Card Number	
Email Address		Mobile	
Principal Member		Employee Number	
Bank A/C Number		Bank Name	
IBAN (23-digit)			

2. CLAIM DETAILS

Location	UAE		☑	Overseas(O/S)		☑	Country if O/S
Name of Hospital/Clinic/Doctor							
Date of Treatment		Currency			Number of Invoices		
Total Amount Claimed							

For breakdown of Total Amount Claimed, use attached summary table cover sheet to tabulate entries in chronological order

3. MEDICAL DETAILS- to be completed by the treating doctor

Chief Complaint							
Diagnosis							
Is This Case Work Related?	NO		☑	YES		☑	Specify if Yes
Treatment Type	Inpatient		Outpatient			Day Care	
Treatment Details							

I, the undersigned treating doctor, hereby declare I have attended to this patient and the particulars provided are correct and accurate to the best of my knowledge.

Doctor Name and stamp		Signature		Date	dd/mm/yyyy

4. DECLARATION- Please tick all three boxes below

☑ **Correct Information**

I, the Undersigned, in the stated capacity hereby declare that the above information is correct and that the reimbursement requested is for the actual expenses paid by me, for the treatment of the claimant's covered condition, for which no previous claim has been applied.

☑ **Supporting Documents**

I, the undersigned, in the stated capacity hereby authorize any doctor, hospital, clinic, and/or health care provider, any insurance company or any company, institution or any other person who has any record or information about the claimant and/or any of the claimant's family members to provide Oman insurance Company (P.S.C.) with the complete, correct and accurate information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization or any other information required by Oman Insurance Company (P.S.C.).

☑ **Anti-Fraud**

I, the undersigned, in the stated capacity hereby declare that I am fully aware that any person, who intentionally makes any false and/or misleading statement and/or information to obtain reimbursement from Oman Insurance Company (P.S.C.), is subject to penalization. In such event Oman Insurance Company (P.S.C.) will have the right to recover any or all amounts that Oman Insurance Company (P.S.C.) may have reimbursed or incurred under the subject claim including litigation costs, if any.

This authorisation shall bind the Claimant's successors and remains valid not withstanding death or incapacity. A photocopy or facsimile copy of this authorisation shall be as valid as the original.

The receipt of this reimbursement claim form/other supporting/related documents does not constitute or be deemed to constitute acceptance of liability under the claim and all the right to process or reject or require further/additional information in respect of the claim are reserved

Name		Signature		Date	dd/mm/yyyy
Authorised Signatory	Signatories relationship to Card Holder / Claimant / Insured / Principal Member / Duly Authorised Representative				

How to complete this form

To be Completed by You
To be Completed by your Doctor

REIMBURSEMENT CLAIM FORM

شركة عُمان للتأمين (ش.م.ع.)
Oman Insurance Company (P.S.C.)

- Please write in BLOCK LETTERS, complete in full, and submit within 30 days to ensure timely processing.
- For the required supporting documentation; use the attached Summary Table as cover sheet.
- Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections.
- One Claim Form Per Person, Family members must apply Individually.

1. MEMBER AND PAYMENT DETAILS

Claimant Name	
Policy Number	
Email Address	
Principal Member	
Bank A/C Number	
IBAN (23-digit)	

Enter the patient and card details as per the OIC Insurance Card. Show the name of your employer to help us identify your benefits. Give us your contact details so we can keep you informed on the progress of your claim by SMS or by e-mail.

Enter the bank details including the IBAN of the account where we can transfer your settled claim amount.

2. CLAIM DETAILS

Location		verseas(O/S)		Country if O/S	
Name of Hospital/Clinic					
Date of Treatment	D D M M 2 0 Y Y	Currency		Number of Invoices	
Total Amount Claimed					

For breakdown of Total Amount Claimed, use att… …in chronological order

3. MEDICAL DETAILS- to be completed b…

Chief Complaint			
Diagnosis			
Is This Case Work Related?	NO		
Treatment Type	Inpatient		
Treatment Details			

Enter the details and location of the treatment facility, nature and date of treatment, the total claimed amount, currency and the number of invoices you are submitting. Complete the summary table on the next page giving the full required details. Every invoice should be on one line. Only the invoices stated on the summary sheet will be considered. Make photocopies if more lines are needed.

I, the undersigned treating doctor, hereby declare I have attended to this patient and the particulars provided are correct and accurate to the best of my knowledge.

Doctor Name and stamp		Signature	

This section is to be filled by your treating doctor. Include the diagnosis and full details of the treatment, etc. Ensure your doctor has signed and stamped the form.

4. DECLARATION- Please tick all three boxes below

☑ **Correct Information**

I, the Undersigned, in the stated capacity hereby declare that the above… …d
is for the actual expenses paid by me, for the treatment of the claimant's … …applied.

☑ **Supporting Documents**

I, the undersigned, in the stated capacity hereby authorize any doctor, hospital, clinic, and/or health care provider, any insurance company or any company, institution or any other person who has any record or information about the claimant and/or any of the claimant's family members to provide Oman insurance Company (P.S.C.) with the complete, correct and accurate information, including copies of their records with reference to any sickness… …any other information required by Oman Insurance Co…

☑ **Anti-Fraud**

I, the undersigned, in the state… …ny false and/or misleading statement and/or inform… …penalization. In such event Oman Insurance Company … …Company (P.S.C.) may have reimbursed or incurred under the…

This authorisation shall bind the Claimant's successors and remains valid not wit… …as valid as the original.

The receipt of this reimbursement claim form/other supporting/related docume… …n and all the right to process or reject or require further/additional information in respect of the cl…

This section is to be read carefully by the Claimant the Principle Member and/or the duly authorised signatory followed by the concerned signature. This will be considered as your agreement to the statements therein. You can also use this space to emboss your company's stamp if your HR department requires you to do so.

Name			…te
Authorised Signatory	Signatories relationship to Card Holder / Claimant / Insured / Principal Member / Duly Authorised Representative		

Registered under UAE Federal Law No. 6 Of 2007 Registration No. 9, Commercial License No. 203970

REIMBURSEMENT CLAIM FORM - Attachment

FORM NUMBER

R | I | 58616551

شركة عمان للتأمين (ش.م.ع.)
Oman Insurance Company (P.S.C.)

SUMMARY TABLE OF SUBMITTED INVOICES - mark the sequence number on the corresponding invoice

Sequence Number	Service Date	Provider Name(s)	Services Description	Invoice Ref. Number	Claimed Amount	Currency
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					
	dd/mm/yyyy					

In case you have more invoices to send, please photocopy this sheet.

CHECKLIST - Before you submit, please check that you have included all of the following as applicable:

	✓
1. Completed, stamped and signed Reimbursement Claim Form	
2. Pre-approval letter form Oman Insurance company where required (refer to TOB)	
3. Original invoices/bills showing payments confirmation	
4. Medical and/or Lab test reports	
5. All claims submitted must be in original & translated to either English or Arabic for the settlement	
6. Card copy of the concerned member.	
7. Summary Table of Submitted Invoice (above) completed	
8. You have retained a copy of the Form, Summary Table and original invoices and report for your reference	

MEDICAL CLAIMS CENTRE

P.O. Box - 5209

Level 3, Al Rigga Business Centre

IBIS Hotel Building, Al Rigga Street, Deira. Dubai.

Ph: +971 4 230-2700 | Fax: +971 4 238-4310 | Email: oicem@tameen.ae

For more information contact :

Call centre : 800 4746 (within UAE)

Or Email for

Pre Authorisation - medpar@tameen.ae

Network - mednetwork@tameen.ae

Claims Follow up - medclaims@tameen.ae

شركة عمان للتأمين (ش.م.ع.)

Oman Insurance Company (P.S.C.)

P O Box 5209, Dubai, U.A.E. Ph: +971-4-233 7777, Fax: +971-4-233 7775

Email: oicem@tameen.ae, www.tameen.ae Toll Free: +971-4-800 4746 (within U.A.E.)