

DENTAL REIMBURSEMENT CLAIM FORM



PATIENT DETAILS

Patient's Name		Patient's Card Number			
Patient's Email Address		Patient's Telephone Number			
Patient's Address	P.O. Box	Country		Patient's Fax Number	

DETAILS OF CLAIMED AMOUNT

Provider's Name: _____ CURRENCY AS PER INVOICES: _____

DENTAL TREATMENT	DATE	AMOUNT	DATE	AMOUNT	DATE	AMOUNT
Procedure Type						
Consultations						
Pharmacy /Others						
TOTAL AMOUNT as per invoices						

DECLARATION

I hereby warrant the truth and completeness of all statements and authorize any Medical Attendants who have attended to me at any time to provide any health details or medical records that may be requested by GCIC or their appointed representatives. And I hereby authorize GCIC to pay the eligible expenses as per the policy terms and conditions directly to the policy holder/member and in local currency (AED).

Submitter's Name _____ Signature _____ Contact Number _____ Date _____ Relationship to the Patient _____

MEDICAL INFORMATION (to be filled by the treating Doctor)

DIAGNOSIS	Visit Date ____/____/____ dd mm yyyy	
Treatment Details	Tooth No.	
Further Treatment Plan		
I declare that I have attended to this patient and that the particulars given are best of my knowledge true and correct.		
Doctor's name over signature	Date & Stamp	

EMPLOYER'S SECTION (to be attested by HR Department/Insurance Coordinator)

Cheque payment is to be collected by: Employer Employee Others (specify) _____
 Name and signature _____ Date _____