MaxMedical
We Listen. We serve. We care.

MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

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DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

REIMBURSEMENT FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and fully completed form. All documents will be handled in strict confidence by our medical team. Failure to provide the required information may result in your claim not being settled.

1. PATIENT INFORMATION

Surname					
First Name					
Date of Birth (dd/mm/yyyy)		Age		Card No.	
Address					
Tel. No.				Fax No.	
Email					

2. BANK DETAILS (COMPULSORY)

Account Holder Name			
Bank Name		SWIFT Code	
Bank Address		Currency	
IBAN			

3. MEDICAL INFORMATION (To be completed by the Physician)

Presenting symptoms			
Date when symptoms first occurred			
Has this or any similar condition existed previously?	☐ Yes ☐ Nosdf	If yes, please provide details/dates*:	
Diagnostics / Investigations			
Treatments / Medications			
Provisional diagnosis			

*Please continue on a blank sheet if more space required

4. PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries /illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature .....

Date .....

5. PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish MSH International information with regard to any medical history, condition or services. I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature .....

Date .....

Version: 04.12.2017

Reset form