Reimbursement Claim Form

ضمان Daman

1. Card Holder's Identity and Contact Information:

Name:* *(Exactly as printed on the Daman card)* BEDROS MOUSES BEDERSJIKIAN

Daman Card No:* 8 0 8 5 3 6 1 | Mobile No.:* 050-6112385

E-mail Address:* bedros.b@mace contractors.com

2. Claims Payment Details

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

Beneficiary Name: BEDROS MOUSES BEDERSJIKIAN	
Bank Name: ADCB	Branch, Bank Address: Abu Dhabi
Account Number:	Swift Code Number (For International Transfers)
IBAN: AE650030000288039032001	

I authorise the National Health Insurance Company – Daman PJSC ("Daman") to make wire transfer payment against this Reimbursement Claim Form and hereby discharge Daman from any liability with respect of releasing the payment to the bank details as specified by me hereinabove.

3. Information on Road Traffic Accident, Work Related, Third Party Liability and Double Insurance *(Refer to 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

4. 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: sever pain in his wisdom 8|

Diagnosis: periapical periodontitis

Treatment Details:

Ext 8

د. اميرة حسن
Dr. Amira Hassan
ممارس عام - طبيب اسنان عام
G.P General Dentist
MOH License No. D57288
Orchid Medical Centre

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

Amira Hassan — Name *(Medical Practitioner)*

Signature

29-8-2020 — Date

Stamp

5. 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.

6. Declaration

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, 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 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.

BEDROS MOUSES BEDERJ — Name of Card Holder/ Legal Guardian/ Legal Representative

Signature

30-08-2020 — Date

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C009977)

Patient File #	:	**1005602**	Visit Date	:	**29-08-2020**
Patient Name	:	**BEDROS MOUSES BEDERJIKIAN**	Insurance	:	**Cash**
Doctor	:	**DR.AMIRA**	Invoice Date	:	**29-08-2020**
VAT Reg #	:	**100479302000003**			

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	CPT024	Extraction (Simple)	500.00	1	500.00	0.00	0.00	0.00	500.00

Gross Total (in AED)	**500.00**
Discount (in AED)	**0.00**
Net Total (in AED)	**500.00**
VAT TOTAL	**0.00**
NET + VAT TOTAL	**500.00**
Paid (in AED) **(Cash)**	**-500.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**0.00**

Prepared By Rana

1 DENTAL EXTRACTION

RECEIVED
ORCHID MEDICAL CENTER

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER (No.REC-011139)

Date:29-08-2020

Receive from Mr./Mrs./M/s. **1005602 - BEDROS MOUSES BEDERJIKIAN - 971506112385**

The sum of Dhs. **Five Hundred Dirhams and Zero Fils Only**

By Cash **500.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **29-08-2020**

Being **1 DENTAL EXTRACTION**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : 1005602 - BEDROS MOUSES BEDERJIKIAN - 971506112385

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

RECEIVED
ORCHID MEDICAL CENTRE