Administered by:

NOW HEALTH INTERNATIONAL

Insured by:

Arabia INSURANCE

Claim form: Medical Providers

Important information for Medical Providers:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within 30 days from the end of the month in which **Treatment** is given, or as per the contractually agreed submission period.

You can scan this claim form, receipts/diagnostic reports/discharge reports and membership card, and email them to ClaimsService@now-health.com or fax them to +971 (0) 4450 1416.

If you have any questions about this form, please call us on +971 (0) 4450 1410 or email us at ClaimsService@now-health.com.

Section 1: Member and Patient Information: (to be completed by the patient)

Planholder's name:	
Patient's name:	
Membership number:	Date of birth (dd/mm/yyyy): / /
Gender:	Telephone number:
Medical record number (if available):	

Section 2: Medical Information (to be completed by the doctor responsible for the patient's **Treatment**):

Provider name:		
Provider address:		
Medical Condition:		
Diagnosis ICD 10 code:	**Treatment** date (dd/mm/yyyy): / /	
Type of claim: Illness ☐ Injury ☐ **Accident** ☐		
If the claim is due to an **Accident** and some of the costs are recoverable from a third party (for example a person or organisation involved in the **Accident**), please provide details:		
Type of condition: Acute ☐ Chronic ☐ Maternity ☐ Congenital ☐		
Type of service: **Out-Patient** ☐ **Day-Patient** ☐ **In-Patient** ☐		
For **In-Patient or Day-Patient Treatment**	Admission date (dd/mm/yyyy): / /	Discharge date (dd/mm/yyyy): / /
Treatment/Medication details:		
Date on which the patient first consulted you for this **Medical Condition** (dd/mm/yyyy):	/ /	
Date on which the first onset of symptoms have been apparent to the patient (dd/mm/yyyy):	/ /	
Did the patient receive any **Treatment** in the past for this **Medical Condition**? If yes, please provide details (include medical reports)		
Total claimed amount:	Currency claim incurred in:	

Medical Practitioner Declaration:

I declare that I am the patientís **Medical Practitioner** and that:

1. The particulars given herein are, to the best of my knowledge, true and correct
2. I have applied the conditions detailed in the Provider Agreement and Manual held with Now Health, where applicable; and
3. The **Plan** member's claim detailed herein is covered by their **Plan Benefits** and that if any payment is invalid Now Health shall be entitled to recover the erroneous payment.

Print name:	Official stamp:
Signature:	
Date (dd/mm/yyyy): / /	

Section 3: Important notes

Data Protection

Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

We and the Underwriters will deal with all personal information supplied in the strictest confidence as required by the Personal Data Protection Act. **We** and **Your** underwriters collect personal information about **You** and **Your** Dependents (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administrating **Your Plan**, Underwriters, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside **Your** country of residence. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the country of **Your** residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organizations without **Your** consent.

You have a right of access to, and correction of, information that we hold about **You**. Please contact **Us** if You would like to exercise either of these rights. Some of the information We collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the plan, including claims correspondence, will be sent to the **Planholder**. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practice may be impaired.

Please contact our Customer Services team or write to us at the address on the back of this form if **You** wish Now Health International group companies to contact **You** via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com/privacy

Your health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

Sanctions Limitation and Exclusion

We will not provide cover nor pay claims under this **Plan** if **Our** obligations (or the obligations of **Our** group companies & administrators) under the laws of any relevant jurisdiction including UAE, UK, European Union, the United States of America, United Nations resolutions, trade or economic sanctions or international laws sanctions, prevents or restricts **Us** from doing so.

We will not provide You with any services or benefits including but not limited to acceptance of premium payments, claim payments and other reimbursements if in doing so, **We** violate applicable law, regulation, code or court order or are or will be otherwise sanctioned, prevented or restricted.

We may terminate Your Plan if **We** consider **You** or **Your** directors or officers as sanctioned persons, or **You** conduct an activity which is sanctioned, according to trade or economic laws & regulations.

Section 4: Patient declaration and authorisation

Declaration

I hereby declare that I am the patient/patientís guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

I consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International Limited, PO Box 482055, Dubai, UAE.

I have read the important notes and the declaration.

I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of the **Plan**.

Patientís signature **Date** (dd/mm/yyyy):

/ /

Plans issued in the United Arab Emirates (UAE) are insured by Arabia Insurance Company S.A.L.
(registered under UAE Federal Law No (6) of 2007 and regulated by CBUAE) with the Registration No: 20)
Registered address: Arabia Insurance, Green Tower, Floor No 8, 9 and 10. P.O. Box 1050 Dubai United Arab Emirates.

Plans are administered by Now Health International Gulf Third Party Administrators LLC (regulated by CBUAE with the Registration No: 26).
Registered address: Office No: 1741, Al Ghaith Tower, Aya Business Centers – Branch 1, Hamdan Street, Al Dannah, Abu Dhabi, United Arab Emirates.