GlobeMed
Egypt

Reimbursement Claim Form

All fields marked with (*) are mandatory

Insured's Member's Name _____
Individual # * _____
Mobile No.* _____
Insurance Company _____

Type of Claim *
- ☐ New Claim
- ☐ Completion of Missing Documents

Total Claimed Amount _____
Number of Invoices _____

Required Approvals (Please specify the submitted documents by ticking the corresponding fields)

Outpatient Services

Medical Consultation

- ☐ Original medical prescription including the insured member's name, prescription's date and diagnosis
- ☐ Original doctor's invoice or noncommercial profession invoice including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Medications

- ☐ Original medical prescription including the insured member's name, prescription's date, diagnosis, and prescribed medications.
- ☐ Original medications invoice detailing the price of each medication, insured member's name and date. The invoice should be stamped or in digital or electronic form.

Total Paid Amount _____

Lab Tests

- ☐ Original medical report (lab test request) including the insured member's name, test's date, and diagnosis.
- ☐ Copy of the lab tests results
- ☐ Original invoice of the laboratory tests including the insured member's name, and date. The invoice should be stamped.

Total Paid Amount _____

X-rays

- ☐ Original medical report (X-ray request) including the insured member's name, procedure's date, and diagnosis.
- ☐ Copy of the X-ray results
- ☐ Original invoice of the X-ray tests including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Physiotherapy

- ☐ Original medical report (physiotherapy sessions request) including the lab tests results, the insured member's name, sessions' date, and diagnosis.
- ☐ Original sessions record along with the date of each session.
- ☐ Original invoice from the physiotherapy center including the insured member's name & date. The invoice should be stamped.

Total Paid Amount _____

Inpatient Services

- ☐ Original medical report detailing the reason of admission, condition upon admission along with the insured member's name, date of admission & diagnosis.
- ☐ Copy of all the lab tests results performed during hospitalization.
- ☐ Detailed invoice of medications and other medical items / services
- ☐ Original detailed invoice from the hospital including the insured member's name and discharge date. The invoice should be stamped.
- ☐ Discharge report from the hospital clarifying the condition of patient upon discharge.

Total Paid Amount _____

Additional Services

Dental Services

- ☐ Original medical report including the insured member's name and service date.
- ☐ Original doctor's invoice detailing the price of each service/item, tooth number, insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Optical Services

- ☐ Original optometry test result including the insured member's name and date of service.
- ☐ The original invoice of the eyeglasses including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Pregnancy and Delivery

- ☐ Medical report and invoice with the amount paid, insured member's name, date, and diagnosis.
- ☐ Delivery: birth certificate of the newborn and all the documents required for treatment within the hospital (all invoices should be detailed, separated for each service and stamped).
- ☐ Ultrasound result detailing the service date and the amount paid for the ultrasound.

Total Paid Amount _____

Bank Account Details

Bank Name * _____
Branch * _____
Beneficiary Full Name * _____
Account Number * _____

I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and / or any of my family members to provide GlobeMed Egypt with the complete information, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

SUBMIT BY EMAIL

Client Signature and Date _____