NEXtCARE®
Your Health Managed with Care

REIMBURSEMENT CLAIM FORM

Please Complete Clearly (All Fields Mandatory)

ADMINISTRATIVE

Policy Number:	Group Name:	Payer Name:
Patient's Name:	DOB: dd/mm/yyyy	Date of Service: dd /mm /yyyy
Staff No:	Claim No:	Authorization No:
Staff Bank Account No:	Staff IBAN Number:	Account Name:

Documents in other language than Arabic, English or French should be translated before submission to NEXtCARE

Enclosed required copy documents:
☐ **Detailed medical report** ☐ **NSSF Prescription** ☐ **Itemized invoice** ☐ **Receipt** ☐ **Results**

OBJECTIVE / ASSESSMENT *(To be completed by NEXtCARE reimbursement team)*

Decision:	☐ Approved	☐ Partially declined	☐ Totally declined
Declined reason:			

Clinical Details & Description of Present Case:

Cause: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related
☐Acute ☐Chronic ☐Confirmed ☐Suspected ☐Other

Assessment / Diagnosis:	**Specific Assessment code:**

MEDICAL PLAN

MEDICAL PLAN	*Claimed Amount*	*Approved Amount*	*Beneficiary Share*	*Payer Share*
☐ **In-patient**				
☐ **Emergency**				
☐ **Ambulatory (Lab; X-Ray…)**				
☐ **Physiotherapy**				
☐ **Pharmacy**				
☐ **Doctor Consultation**				
☐ **Dental**				
☐ **Clinical Procedures**				
TOTAL CHARGES				

Patient's Signature (Parent if minor):	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to NEXtCARE for the purpose of determining insurance benefits.*
Date:	

Payer's Signature :	*NEXtCARE Signature :*
Date:	*Date:*