MaxCare Middle East

Claim Form to be filled by Provider

Member Details:

Patient Name*		Company Name	
MaxCare Insurance Card Number*		Date of Birth*	
Mobile Number*		Emirates ID*	

Provider Details:

Provider Name*		Place *	
Provider License No.*		State *	
Treating Doctor Name*		Qualification Treating Doctor*	
Treatment Start Date*		Treatment End Date*	

Presenting Complaints & Duration*

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Medical Details:

Weight*	Kgs	Pulse Rate	/Min
Temperature *	F	Blood Pressure	Systolic/ Diastolic/

History of any Past illness / Past Treatment given

If Patient is on any Treatment PLEASE SPECIFY____________________

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MaxCare Middle East

Diagnosis Description*		ICD Code*	

Diagnosis* (Please Tick the appropriate)

Pre Existing/Chronic ☐	Maternity ☐	Dental ☐
Optical ☐	None of these ☐	

<u>Investigations Carried Out*</u> <u>Date*</u>

1.___________________________________ ___________________________

2.___________________________________ ___________________________

3.___________________________________ ___________________________

4.___________________________________ ___________________________

5.___________________________________ ___________________________

<u>Medicines Prescribed *</u> <u>Date*</u>

1.___________________________________ ___________________________

2.___________________________________ ___________________________

3.___________________________________ ___________________________

4.___________________________________ ___________________________

5.___________________________________ ___________________________

<u>Signature of Treating Doctor</u>

<u>License Number</u>

<u>Name</u>

<u>Stamp of the Hospital</u>