

HEALTHCARE INSURANCE

REIMBURSEMENT CLAIM FORM

Receive your claim payment faster by updating your bank details on the [mySukoon](#) app or on <https://medical.sukoon.com/>



1. Claimant Details

1. Claimant Name										
2. Card Number										
3. Mobile Number	0	5								
4. Email Address										

* Use EFT for faster, safer, and convenient reimbursement.
Principal Member can update IBAN by visiting [mySukoon](#) portal on [mySukoon](#) app.
For policies where payment is set to 'group', the IBAN must be provided by your company on the company's letterhead along with the HR/Accounts' email ID.

2. Claim Details

1. Is the claim in UAE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If No, Precise Country								
2. Name of Hospital/Dr.											
3. Date of Treatment			/			/	2				
4. Number of Invoices											
5. Total Amount Claimed											
6. Currency											

For breakdown of Total Amount Claimed, use attached summary table cover sheet to tabulate entries in chronological order.



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3. Medical Details – To be Completed by the Treating Doctor

1. Is it work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Specify	<input type="text"/>
2. Treatment Type	<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Day Care		
3. Chief Complaint	<input type="text"/>		
4. Diagnosis	<input type="text"/>		
5. Treatment Details	<input type="text"/>		

I, the undersigned treating doctor, hereby declare I have attended to this patient and the particulars provided are correct and accurate to the best of my knowledge.

Doctor Name & Stamp	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text"/>
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4. Claimant's Declaration & Authorization

I hereby authorize Sukoon Insurance PJSC (hereinafter referred to as "Sukoon") to wire transfer claim payouts (if any) related to this claim form to the above bank details as updated by me. I understand that Sukoon reserves its right to use any alternate payout option if required. If ever Sukoon credits more amount than the correct benefit amount due to duplicate or erroneous funds transfer, I authorize Sukoon to revise the transaction and withdraw the overpayment. I will not hold Sukoon responsible or liable in any case of non-credit to the above bank account or if the transaction is delayed or not effected at all for reasons of incomplete/incorrect details filed in by me.

I confirm that all particulars filled are true, accurate and complete. I confirm that all submitted/uploaded documents are true copy(ies) of the original documents. I also confirm my understanding that I am required to retain the original documents for a period of one year, within which Sukoon may request original documents anytime for verification purposes. In the event I do not provide the original or am unable to provide the authenticity of the submitted documents then Sukoon reserves the right to recover paid claim amounts if any.

I hereby authorize (i) the medical provider/other entities to provide & discuss health/treatment details with Sukoon ('Insurer') and/or its third party administrator (ii) the Insurer to (a) disclose my personal/claim information for claim processing or as may be required (b) to use alternate claim payout options if required; and (iii) to contact me anytime and through any medium for providing claim/other insurance products information. I understand that (i) any person, who intentionally conceals, makes false or misleading statement to obtain claim reimbursement, is subject to penalization and legal action (ii) acceptance of claim form does not constitute acceptance of liability by the Insurer.

This authorization shall remain valid notwithstanding death or incapacity. This electronic authorization shall be as valid as the original.

Claimant Name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text"/>
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HOW TO COMPLETE THE FORM

One Claim Form per person, family members must apply individually. For the required supporting documentation, use the attached Summary Table as cover sheet. Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections.

Please submit the form within 120 days of treatment to ensure timely processing. Both you and the attending doctor must fill in the claim form for each individual visit or course of treatment. Please look at the below definitions to understand who is Principal member, Dependent and Claimant.

Principal Member is the **insured employee** under the policy.

Dependent refers to Principal Member's spouse or children.

Claimant is the person undertaking the treatment.

Principal Member: Please fill section 2

- To help us transfer the settled claim amount to you or your dependent's bank account, please update the IBAN of the account on the [mySukoon](#) portal or the [mySukoon](#) app. For policies where payment is set to group, the IBAN must be provided by your company on the company letterhead along with the HR/Accounts email ID. In case the IBAN is not provided, we will issue a cheque which will take 10 additional days.

Claimant: Please fill section 1, 2 & 4

- Fill in your name and card number. Give us your contact details so we can keep you informed on the progress of your claim by SMS or e-mail.
- Include the breakdown of expenses that need reimbursement. Complete the summary table on the next page giving the full required details. Each invoice detail should be on a separate line.
- Read the Declaration section carefully and remember to sign and date the form.

Doctor: Please fill section 4

- Please ensure that the doctor completes each question of the Medical section in full and then signs and stamps it.

Claim Submission

Online	Physical Submission	Courier
<p>Submit your claim online through the mySukoon portal or mySukoon app.</p> <p>For claims above AED 5,000 you will need to submit the original documents.</p>	<p>Deposit your claim at: Your HR department, broker or at one of our branches.</p>	<p>Send your claim by mail to: Medical Claims Department, Sukoon , Omar Bin Al Khattab Street , Next to Al Ghurair Mall, Deira, P.O. Box 5209 Dubai, UAE Tel: +971 4 230 2700</p>

Claim Processing

We aim to pay your complete eligible claims within 10 calendar days. Please remember that we will reimburse you as per the customary prices in our network. This means that if your doctor charges a general consultation fee of AED 400, when the average consultation fee is AED 250 in your applicable network, we will reimburse you on the basis of AED 250. Moreover, if mentioned in your table of benefits, we might apply a co-insurance over and above your network deductible. If it does, we usually apply 20% co-insurance. In the above example, if your network deductible is AED 50, we will apply 20% co-insurance on AED 200, and reimburse AED 160.



SUMMARY TABLE OF INVOICES

REIMBURSEMENT CLAIM FORM ATTACHMENT

Mark the sequence number of the corresponding invoice.

Sequence Number	Service Date	Provider Name	Service Description	Invoice Ref. Number	Claimed Amount	Currency

In case you have more invoices to send, please photocopy this sheet.

Checklist - Before you submit, please check that you have included all of the following as applicable:	✓
1. Completed, stamped and signed Reimbursement Claim Form	
2. Original invoices/bills showing payments confirmation	
3. Medical and/or Lab test reports	
4. All claims submitted must be in original & translated to either English or Arabic for the settlement	
5. Healthcare Insurance card copy of the claimant	
6. Summary Table of Invoices (above) completed	
7. You have retained a copy of the Form, Summary Table and original invoices and report for your reference	

Claimant Name & Signature		
Name	Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

<p>If you have any enquiries, contact us on:</p>	<p>800 SUKOON (785666) UAE Toll Free 8 am till 8 pm Monday to Friday, 8 am till 5 pm on Saturday Fax: +971 (0) 4 238 4769 weserve@sukoon.com</p>
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