MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

CLAIM FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and fully completed form. All documents will be handled in strict confidence by our medical team. Failure to provide the required information may result in your claim not being settled.Thankyou

1 PATIENT INFORMATION

Surname	Card No.	
First Name	**Mobile Doctor ID.**	
Address		
Tel. No.	Fax No.	
D.O.B./Age	Email	

2 TREATING FACILITY INFORMATION

TREATING MEDICAL OFFICER / REFERRING DOCTOR		HOSPITAL / MEDICAL FACILITY	
Name	:	Name	:
Tel. No.	:	Tel. No.	:
Fax. No.	:	Fax. No.	:
Email	:	Email	:
Address	:	Address	:

3 MEDICAL INFORMATION (to be completed by the Physician)

Presenting symptoms		
Date when symptoms first occurred		
Has this or any similar condition existed previously?	⓿ Yes ⓿ No	If yes, please provide details/dates*:
Diagnostics / Investigations		
Treatments / Medications		
Provisional diagnosis		

*Please continue on a blank sheet if more space required

4 PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries /illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature: _____

Stamp

Date: _____

5 PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish MSH International information with regard to any medical history, condition or services. I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature: _____

Date: _____

MSH International -DIFC, Liberty House, Office No: 304, Level 3 , P.O Box 506537, Dubai, United Arab Emirates
Tel: +971 4 3651340 -Fax: + 971 4 4289264 -E-mail: approvals@mena.msh-intl.com -Web Site: www.msh-intl.com/mena

Important Note :Please fill up the Mobile Doctor ID number if it is mentioned as mandatory on the Insurance Card