Reimbursement Form (Medical part)

Please Use BLOCK letters to fill this form, and ensure that all sections are completed.

Section 1 - Member Information

Patient name (as printed on card)	Saad Belhoussine		
Patient card number	C445-723F-EF29-2FAD	DOB	23/08/1986
Principal name (as printed on	Saad Belhoussine		
Principal contact information	E-mail: saadobel@gmail.com	Mob:	0555411007

Section 2 - Medical Information

(To be fully completed by patient's medical practitioner - all boxes must be completed in BLOCK letters.)

Country of treatment UAE	Provider name and contact information Queen's Medical Center
Date when first symptoms were noticed 02/06/2025	Physician name and contact information Dr. Amer Alkadri
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Physician signature and official stamp QUEENS MEDICAL CENTER Dr. Amer Alkadri General Dentist LICENSE No. 77232670-004 Date 02 / 06 / 2025

Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s).

Symptoms: Pain on cold on front tooth

Diagnosis: Irreversible pulpitis on # 22

Treatment / investigation: Root canal endodontic therapy on #22

Patient name	Saad Belhoussine	Card number	C445-723F-EF29-2FAD

Reimbursement Form (Financial Part)

Section 3 - Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
Total claimed amount per currency:							

Section 4 - Settlement (Kindly ensure bank details are in print form)

Settlement currency:	Settlement by: ☐ Cheque ☐ Wire Transfer
(A) Bank name	(B) Account holder name
(C) IBAN number / Account number	(D) SWIFT code
(E) Bank address	(F) Beneficiary address

Important Notes:

Please submit the medical reports from your treating physician, pharmacy prescriptions, investigations requests and their results, invoices with itemized breakdown and original receipts. In case of online submission, please retain the original documents as they may be required to finalize your claim.

NAS prior approval is required for all non-emergency hospitalizations. Before admission, you are kindly required to e-mail a detailed medical report and cost estimate of the proposed treatment on official letterhead duly signed and stamped by the treating physician to claimscenter@nas.ae.

Cheques are issued in the name of the principal and are valid for 6 months from the date of issue.

For your convenience, bank account details can be saved and available for editing on your profile page on myNAS portal https://mynas.ntouch.cloud

For transfers within the U.A.E., fields (A), (B) and (C) are mandatory. For transfers outside the U.A.E., please complete all fields in the settlement section above. In case IBAN is not available in the destination country please enter bank account number in lieu of IBAN number. Please note that transfers outside the U.A.E. are subject to charges that may be applied by your bank.

NAS bears no liability for any incorrect bank account details provided above. Furthermore, any charges related to corrective action shall be deducted from the final settlement.

All Documents must be submitted in English or Arabic, documents in other languages must be translated prior to submission.

I, the undersigned, confirm that I am the patient/patient's spouse or guardian (if patient is under 18 years of age) and I wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I authorize and request any hospital, physician, and any other health provider to furnish NAS Administration Services with the complete information including copies of their records in connection with medical treatment and/ or other services provided to me or to my dependent. I also agree that a copy of this consent shall have the validity of the original.	Signature of the principal and or spouse Date / / 20

Queen's Medical Center
Highrise Building #203, 2nd Dec street, Near satwa roundabout, 2nd December Street Al Satwa, Dubai 55951, Dubai
Phone: +971-43533101
TRN : 100441300900003

TAX INVOICE

Bill To

Mr. Saad Belhoussine [15277]
+971 555411007

Invoice # :**S1100669**
Invoice Date :**6 Feb, 2025**

Particulars	Price	Units	Amount	Discount	Net Amount		Total
Dr. Amer AlKadri							
Root Canal Anterior [D3310] [*22*]	800.00	1	800.00	320.00	480.00	0.00	480.00
		Total	**800.00**	**320.00**	**480.00**		**480.00**

Amount in words **Dirham Four Hundred Eighty Only**

For any query please call 581766911.

Thank You,
Queens Medical Center LLC

QUEENS MEDICAL CENTER L.L.C. P.O.Box: 55951 Dubai - U.A.E.

PAID
06 FEB 2025
QUEENS MEDICAL CENTER L.L.C
P.O.Box: 55951 Dubai - U.A.E

Name and Signature

I confirm that the above treatment/s is/are completed to my satisfaction and I promise to pay in full and PAYMENT IS NON REFUNDABLE. . If package is discontinued, amount paid is forfeited.