

Reimbursement Form

Card Holder's Name: _____ Card No.: _____
Valid Until: _____ Contact Telephone: _____

To be completed by the treating Physician

Dear Doctor: The beneficiary participating in the MedNet Program is consulting you for medical care and kindly requests you to complete this form.

Diagnosis : _____

Date of onset of symptoms : _____
If, hospitalized : Date of Admission _____ Discharge _____
Case Management : _____

Actual Costs : _____

Treatment Plan

Diagnostic Tests	Pharmaceuticals
_____	_____
_____	_____
_____	_____
_____	_____

Date

Cardholder's signature

Physician's Name

Telephone No.

Date

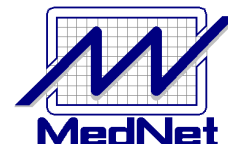
Physician's Stamp and Signature

MedNet Bahrain W.L.L.

P.O. Box 21643, Manama – Kingdom of Bahrain

Tel.: +973 175 66 175 Fax: +973 175 83 006 E-mail: support@mednet.com.bh Web: www.mednet-bahrain.com

Strictly Confidential – Contains Medical Information. Not To Be Duplicated or Handled By Unauthorized Personnel



CHECKLIST

- Completed "Reimbursement Form"
- Full and Complete Medical Report / Diagnosis / Discharge summary from the treating doctor
- Original itemized invoices or receipts for the amount claimed (Invoice must show cost per service)
- Personalized SOAP / Maternity SOAP / Dental SOAP (if applicable)
- Copies of results of diagnostic tests

For treatment of non-network providers, the claim must be submitted **within 60 days** from the date of treatment.

IN-HOSPITAL NON- EMERGENCY ADMISSION

The MedNet Bahrain Call Centre should be notified, at least 7 days in advance for arranging elective treatment on free access basis at a network facility outside Bahrain, if applicable.

Within Bahrain (24 hours a day, 7-days a week)

Phone - +973 175 66 888

Fax - +973 175 83 009

Outside Bahrain (24 hours a day, 7- days a week)

Phone - +201 0 188 4045 (Thomas Cook)

Email: Support@mednet.com.bh

Bank Details	
Name:	
Address:	
Account No.	
IBAN:	
SWIFT Code:	
Account Holder Name:	

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