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THE HEALTH INSURANCE CLAIM GUIDEBOOK

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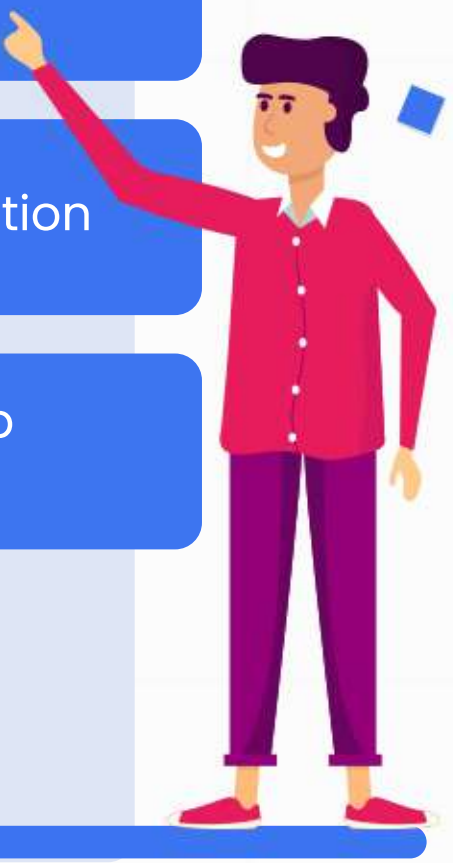

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KNOW THE TERMS, KNOW YOUR CLAIM

Cashless Claim

A claim where the insurer pays the hospital directly. No upfront payment is needed.

Claim Form

A document that you fill and submit to initiate a claim.

Deductible

A fixed amount you must pay before insurance coverage kicks in.

Claim Rejection

When your claim is denied due to reasons like missing documents or non-coverage.

Co-payment

A fixed percentage or amount you must pay from the total bill.

Discharge Summary

A hospital report given at discharge. It outlines the diagnosis, procedures, and treatment.

Insured / Beneficiary

The person who receives the coverage or treatment under the policy.

Medical Report

A summary from the doctor about diagnosis and treatment. This is often required for claims.

Network Hospital

Hospitals that have a tie-up with your insurer to provide cashless treatment.

Non-Network Hospital

Hospitals not covered under your insurer's cashless list. Claims are reimbursed.

Premium

The amount you pay (monthly or yearly) to keep your insurance active.

Reimbursement Claim

A claim where you pay the bills first and later claim the amount back from the insurer.

Sum Insured

The maximum amount the insurer will pay for claims in a year.

TPA (Third-Party Administrator)

A company that manages claim processing on behalf of the insurance provider.

Policyholder

The person who owns the insurance policy.

Pre-authorisation

Approval from the insurer before treatment begins (mainly for cashless claims).

TYPES OF CLAIMS IN THE UAE

Two Ways to Claim — Which One Works for You?

When it comes to claiming your health insurance in the UAE, there are two main methods. Each one is suitable for different scenarios.

1. Direct (Cashless) Claims - Within The Network

This is when you don't pay the hospital upfront. Rather, your insurer settles the bill directly with the hospital. This is done as long as it's part of your insurance network and the treatment is pre-approved (if required).

This method is fast and quite easy. It is commonly used at network hospitals across Dubai, Abu Dhabi, Sharjah, and other emirates.

2. Reimbursement Claims – Outside the Network & Overseas

Here, you pay for the treatment first. Later, you claim the expenses back from your insurer. It's usually used when visiting a non-network hospital or in urgent situations where pre-approval isn't possible.

You'll need to submit documents and proof of payment to get reimbursed.

Quick Tip

Always check whether your hospital is in your insurer's network before Choosing between cashless or reimbursement. This small step can save you a lot of paperwork and time later!

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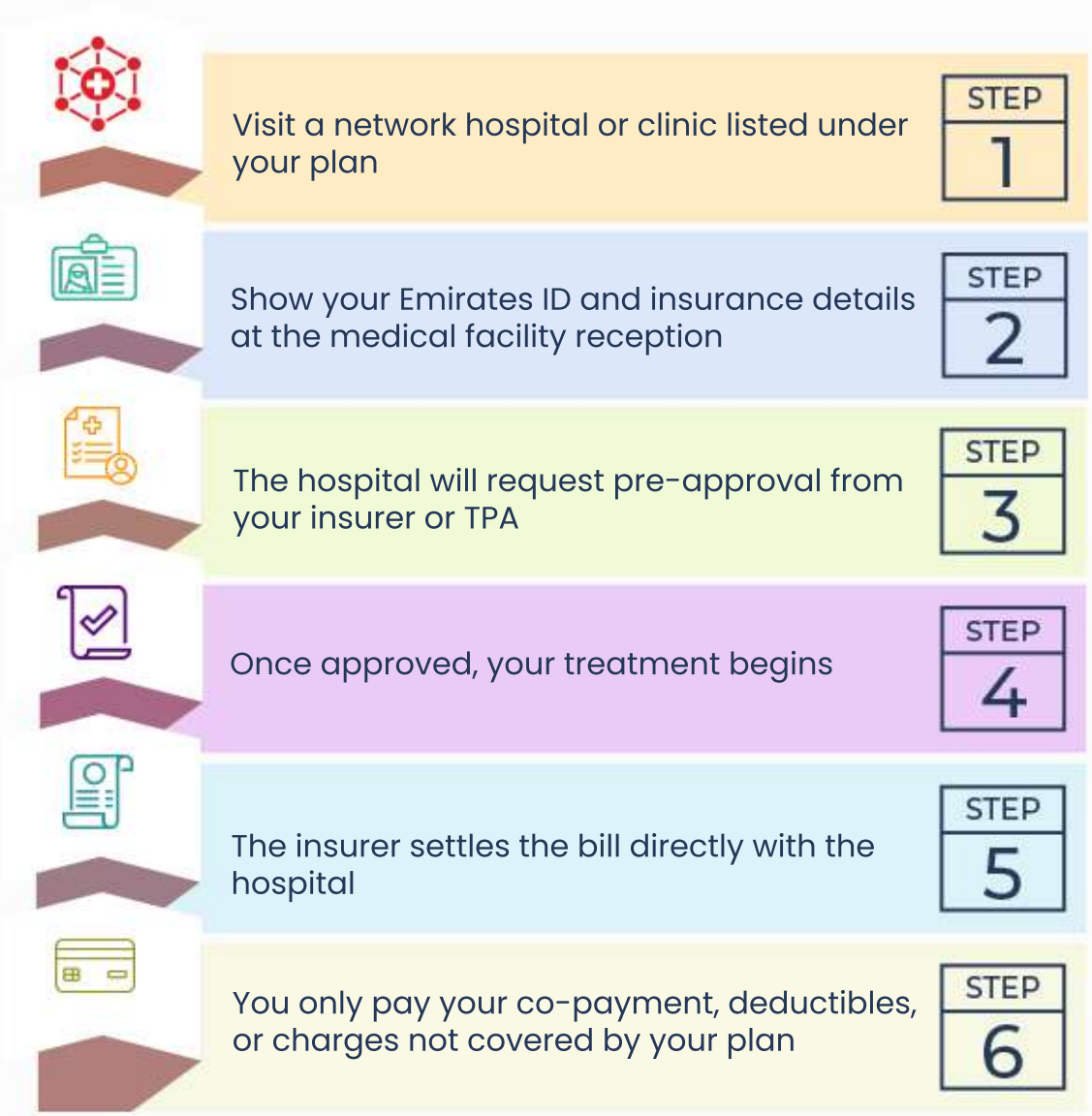
CASHLESS CLAIMS (DIRECT CLAIMS)

Don't pay upfront. Let your insurer take care of the bill.

To access the cashless benefit in health insurance, you need to follow the given steps —



The steps in the claims process may vary slightly depending on the type of treatment you received. Generally, there are three types of claims: outpatient claims for short visits like doctor consultations, lab tests, or X-rays; inpatient claims for treatments that require you to stay in the hospital, such as surgery or recovery; and emergency claims for unexpected health issues like accidents, strokes, or sudden illnesses. Let's take a closer look at each one.

Let's take a look at each case —

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OUTPATIENT TREATMENT

1. Visit a network hospital or clinic (check your insurer's app or website)
2. Present your Emirates ID or insurance card at the reception
3. Doctor consultation takes place
4. If the doctor recommends tests or treatment, the clinic will seek pre-authorisation (if needed)
5. Once authorised, you'll proceed with the treatment or tests
6. You'll only pay your co-payment (e.g., 10–20%) and any other similar charges
7. Sign the claim form before you leave the clinic

INPATIENT TREATMENT

1. Confirm that the hospital is in your insurer's network
2. Present your Emirates ID / insurance card at the admissions desk
3. Hospital submits a pre-authorisation request to your insurer/TPA (with medical reports)
4. Once approved, you are admitted under cashless arrangement
5. During your stay, the insurer continues to monitor approvals for any added procedures
6. At discharge —
   - You sign the claim form and discharge summary
   - You pay only deductibles or non-covered items
7. The hospital directly bills the insurer

For planned admission, get all approvals at least 24-48 hours Before your procedure. For maternity, ask for pre-approval well in advance.

EMERGENCY TREATMENT

1. Go to the nearest network hospital (non-network hospitals may still accept you in emergencies)
2. Show your Emirates ID or insurance card at ER/Reception

   The hospital provides immediate medical care
3. It must also notify the insurer within 24 hours of admission
4. If treatment is approved, it continues as cashless
5. If not approved —
   - You may need to pay and claim reimbursement later
6. At discharge, sign the claim forms and pay only co-payments (if applicable)

Reminder

Even in emergencies, cashless claims are allowed. However, final Approval depends on your insurer's emergency definitions. Always ask The billing desk to initiate insurance contact.

WHEN CAN YOU USE DIRECT OR CASHLESS CLAIMS

- Visiting a hospital or clinic within your insurance network
- For inpatient and outpatient services that are covered
- When pre-authorisation is granted, especially for planned treatments or surgeries

DOCUMENTS REQUIRED FOR CASHLESS CLAIMS

Emirates ID

Insurance card (if applicable)

Doctor's referral (for specialist visits or planned admission)

Previous medical records (if applicable)

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COMMON SCENARIOS WHERE CASHLESS CLAIMS ARE USED

- **Planned Surgeries or Hospital Admissions**
- **Maternity Care** – Including prenatal visits, delivery, and postnatal checkups
- **Pediatric Consultations** – Routine child visits and vaccinations
- **Chronic Illness Follow-ups** – Like diabetes, hypertension, or asthma management
- **Daycare Procedures** – Dialysis, chemotherapy, colonoscopy, or endoscopy
- **Dental Treatments** (if covered under your plan) – Root canal, extractions, cleaning
- **Physiotherapy Sessions** (when prescribed by a doctor and pre-approved)
- **ENT Treatments** – Ear infections, tonsillitis, sinus treatments
- **Diagnostic Scans and Lab Tests** – MRI, X-ray, CT scan, blood tests
- **Dermatology Consultations** (non-cosmetic skin conditions only)
- **Ophthalmology Services** – Eye checkups and non-cosmetic treatments
- **Mental Health Consultations** (if mental wellness is part of your policy)
- **Emergency Admissions** – Where pre-authorisation may follow after stabilisation
- **Vaccinations & Immunisations** (under preventive health plans)
- **Allergy Tests & Management** – With prior medical history
- **Urology & Gastroenterology Consultations** – Covered for adults and elderly patients

GENERAL PROCESSING TIME FOR CASHLESS CLAIMS

For cashless claims, approval is usually quick — often within a few hours in emergencies and up to 24 hours for planned treatments.

These claims apply when you receive treatment at a hospital or clinic within your insurer's approved network. The insurer settles the bill directly with the healthcare provider after pre-authorisation, so you don't need to pay upfront (except for co-payment or deductibles).

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REIMBURSEMENT CLAIMS

When you pay first, and claim later.

STEP 01 Pay for your treatment at the hospital, clinic, or pharmacy

STEP 02 Collect all original documents like detailed invoices, bills, medical reports, and more (see detailed list below)

STEP 03 Download and fill out your insurer's claim form

STEP 04 Submit the complete documents — this can be done online through TPA or insurer portal (e.g., Nextcare, Neuron, NAS) or at your insurer's nearest office

STEP 05 Track your claim using your claim reference number

STEP 06 Receive the approved amount into your registered bank account

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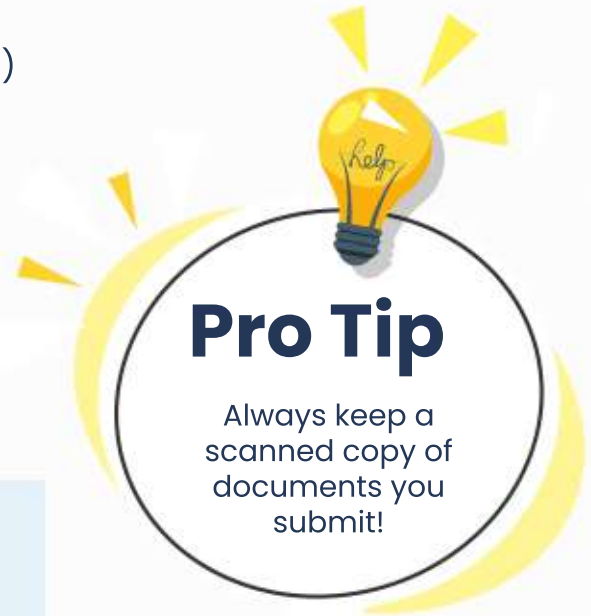
WHEN CAN YOU USE A REIMBURSEMENT CLAIM?

- Visiting non-network hospitals or clinics (locally or internationally)
- In emergency cases when pre-authorisation is not possible
- For overseas medical treatment while travelling
- If you missed carrying your insurance card or Emirates ID

DOCUMENTS REQUIRED FOR REIMBURSEMENT CLAIMS

- Completed and signed claim form
- Original payment receipts and stamped bills
- Doctor's prescription or treatment notes
- Discharge summary (for inpatient)
- Diagnostic test results (e.g., X-rays, blood tests)
- Copy of Emirates ID or policy document
- Bank details (IBAN for reimbursement)



Insurer-specific Forms

Every insurer has its own claim form (ADNIC, Daman, Takaful, AXA, HAYAH etc). Make sure that you're using the correct one.

WHAT'S THE CLAIM SUBMISSION DEADLINE?

In the UAE, you generally need to submit your claim within 30 days of receiving treatment. Some insurers may allow a window of 60 days. Note that delayed submissions may be rejected.

Check your insurer's policy terms for the exact deadline.

GENERAL PROCESSING TIME FOR REIMBURSEMENT CLAIMS

Reimbursement claims take a bit longer to process, usually between 7 to 21 working days after all required documents have been submitted.

This type of claim applies when you pay for the treatment yourself — generally at a non-network hospital or clinic and then submit a claim to get your money back from the insurer.

COMMON MISTAKES THAT DELAY REIMBURSEMENT CLAIMS

Submitting photocopies instead of original receipts

Missing discharge summary or test reports

Handwritten receipts without stamps

Missing or wrong bank details

Using the wrong claim form

Delayed submission beyond 30–60 days

WHAT COSTS ARE NOT COVERED IN CLAIMS?

Even when your treatment is covered by health insurance and the hospital is part of your insurer's network, certain costs may not be fully covered. These are important to understand so you're not caught by surprise at the time of discharge or billing.

- **Co-payment:** This is a fixed percentage of the medical bill that you must pay. The remaining part is paid by your insurer. It usually applies to outpatient consultations, lab tests, or even hospital stays, depending on your plan.

  Example

  Let's say you go to a network hospital in Dubai for a specialist consultation. The total consultation fee is AED 400. If your insurance plan has a 20% co-payment, you will pay AED 80. The insurer will cover the remaining AED 320.

- **Deductible: A deductible** is a fixed amount you must pay first before the insurer begins to cover the cost. It's usually charged per visit or as per the policy term.

  Example

  Imagine you're admitted for a minor surgery and your insurance plan includes an inpatient deductible of AED 500. Even though the surgery is covered and done at a network hospital, you will need to pay AED 500 before your insurer covers the rest of the bill.

- **Non-Covered Treatments or Services:** Some medical treatments are excluded from your policy. The list includes cosmetic procedures, weight loss treatments, alternative medicine, and non-essential services. These must be paid by you, even at a network hospital.

Example

Suppose you request a teeth-whitening procedure while visiting a dental clinic that's part of your network. Since this is a cosmetic (not medically necessary) treatment, your insurance won't cover it. You will need to pay the full cost of the procedure yourself, even though the clinic accepts cashless insurance for other services.

- **Charges Above Sub-limits:** Some policies have caps or limits on specific types of treatment like maternity, dental, or room rent. If the actual expense goes over that limit, you must pay the difference.

  Example

  Let's say your plan has a maternity coverage limit of AED 10,000. You deliver your baby at a network hospital and the total hospital bill is AED 13,500. Your insurer will pay AED 10,000, and you will pay the extra AED 3,500.

- **Room Category Upgrades:** If you choose a room type higher than what your plan covers (like a private suite instead of a shared room), you'll need to pay the extra room charges out of pocket.

  Example

  Your insurance plan covers a standard semi-private room, but you request a private deluxe room during your hospital stay. Let's say the standard room rate is AED 1,000 per night and the deluxe room is AED 1,800. Here, you will need to pay AED 800 per night as the price difference.

- **Treatment Without Pre-Authorisation (Applicable Only for Cashless Claims):** For certain procedures (especially inpatient), prior approval from the insurer is mandatory. If you skip this step, your claim may be partially paid or denied. In this case, you'll bear the cost.

  Example

  You're scheduled for a minor surgery at a network hospital. But you don't wait for the insurer's pre-authorisation and proceed with the operation. Later, your insurer may reject the claim due to missing approval. Here, you may have to pay the full surgery cost on your own.

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CASHLESS VS. REIMBURSEMENT CLAIMS

Feature	Cashless Claim	Reimbursement Claim
Payment at Hospital	No upfront payment (insurer settles the bill directly with the hospital)	You pay the bill first, then claim later
Hospital Type	Only available at network hospitals	Available at any hospital (network or non-network)
Pre-Authorisation	Required for planned treatments	Not required at the time of treatment, but documents needed later
Ideal For	Planned procedures, regular check-ups, and emergencies within network	Emergencies in non-network hospitals, overseas treatment or unavailable specialists in network
Time to Get Coverage	Immediate (once pre-approval is granted)	7–21 (approx.) working days after claim submission
Out-of-Pocket Cost	Only co-payment, deductible, or non-covered services	Full bill amount initially, then reimbursed (partial or full)
Risk of Claim Rejection	Low if treatment is covered and pre-approved	Higher if documents are missing, claim is late, or treatment is excluded
Convenience	Very high – minimal paperwork for the patient	Moderate — more paperwork and follow-ups required

HOW TO TRACK YOUR CLAIM STATUS?

Stay updated and know exactly where your claim stands.

Once you've submitted your medical insurance claim, it's important to keep track of its progress. This ensures you're aware of any missing documents, delays or updates.

Ways to Track Your Medical Insurance Claim

1. Through Policybazaar.ae

- Call us on 800 800 001 and share your claim reference number.
- We will connect with your insurer or TPA, check the status, and update you directly.

2. Through Your TPA (Third-Party Administrator)

- Most TPAs in the UAE (such as Nextcare, NAS Neuron, MedNet) offer online portals and mobile apps to check claim status.
- You'll need your claim number to log in. Sometimes, your Emirates ID may be required as well.

3. Through Your Insurance Provider

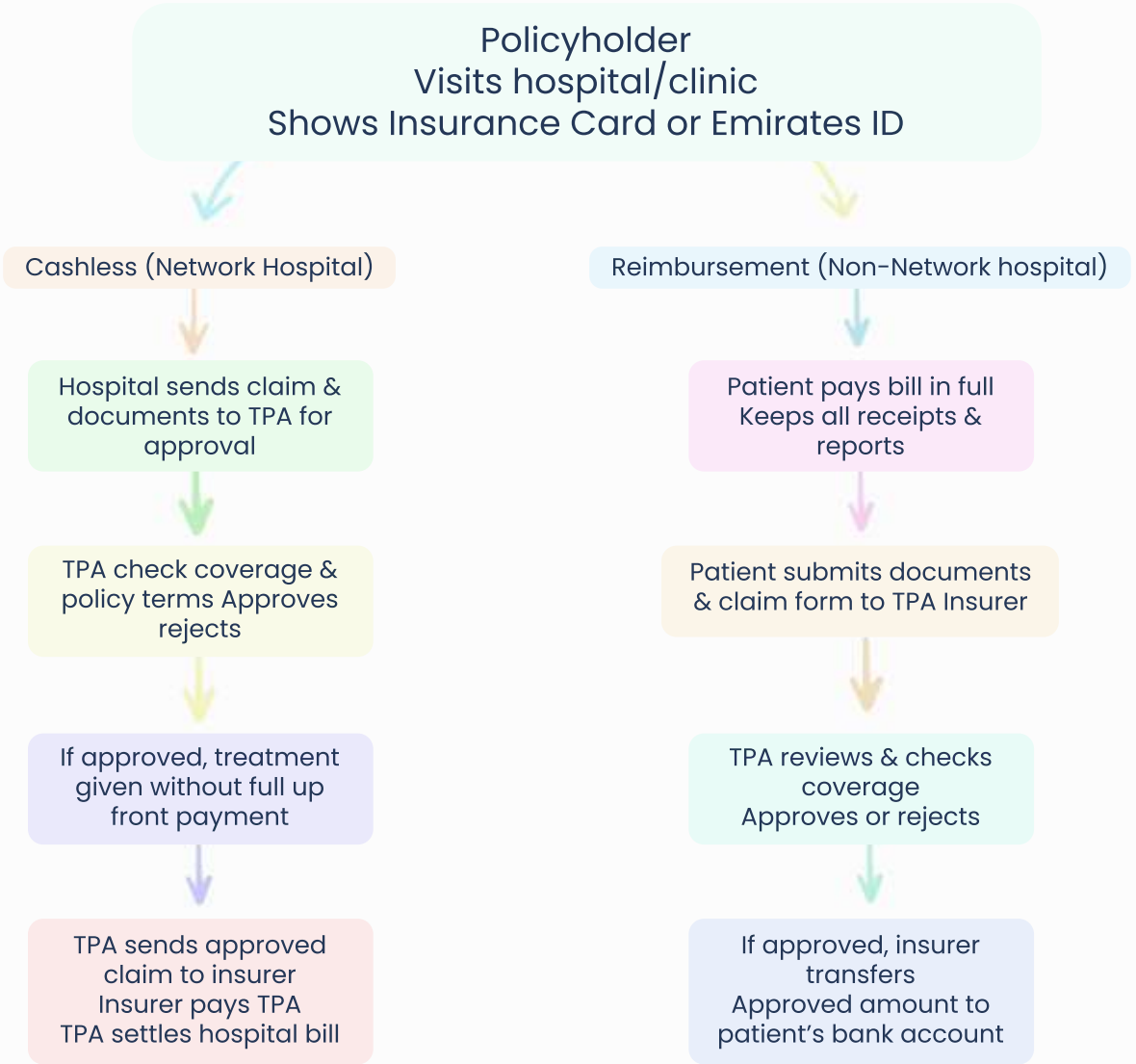
- Many insurers have mobile apps or customer care lines where you can get claim updates instantly.

Tips to Smoothly Track Claims

1. Always keep your claim reference number handy. This is the quickest way to get updates.
2. Check your email regularly. Insurers or TPAs may request extra documents.
3. Respond quickly to any requests to avoid delays.
4. If you haven't heard back within the standard processing time (usually 15–21 working days for reimbursement claims), follow up.

WHAT HAPPENS AFTER YOU FILE A CLAIM?

Know what usually happens after you visit a doctor in the UAE!



CLAIM REJECTIONS & WHAT TO DO

Don't Panic — Fix, Learn, and Reclaim

COMMON REASONS FOR CLAIM REJECTION IN THE UAE

1. **Incomplete or Incorrect Documents** – Missing medical reports, unclear invoices, or unsigned claim forms.
2. **Treatment Not Covered** – Services outside your policy coverage or beyond your policy limits.
3. **Non-Network Provider Without Coverage** – Visiting a hospital not in your insurer's network without reimbursement benefit.
4. **No Pre-Authorisation** – Failing to get required approval for planned treatments.
5. **Late Claim Submission** – Filing your claim after the allowed time window (often 30–90 days).
6. **Policy Waiting Period** – Claim made before your waiting period ends (e.g., maternity cover).

WHAT TO DO IF YOUR CLAIM IS REJECTED?

1. **Read the Rejection Letter Carefully** – Your insurer or TPA will state the reason in writing.
2. **Check Your Policy Terms** – Compare the rejection reason with your coverage details.
3. **Fix Missing Documents** – If it's about incomplete paperwork, gather and resubmit quickly.
4. **Appeal the Decision** – Contact your insurer or TPA directly, explain your case, and provide supporting evidence.
5. **Escalate if Needed** – If you feel the rejection is unfair, you can approach the UAE Central Bank's Insurance Division or the relevant health authority.

Note: Every insurer and TPA in the UAE follows specific procedures for rejections and appeals. Always respond promptly, as delays may close your case permanently.

HOW TO MAKE A CLAIM WITH POLICYBAZAAR.AE?

From buying your policy to getting your claim approved, we are with you at every step.

1. **Understand Your Situation** – We listen to your case and identify if it's a cashless or reimbursement claim.
2. **Check Policy Coverage** – We confirm what's covered under your plan and guide you on what's next.
3. **Document Assistance** – We tell you exactly which documents are needed and how to get them.
4. **Coordinate with TPA/Insurer** – We talk to the right people so that your health insurance claim moves forward smoothly.
5. **Follow-Up Until Settlement** – We keep track of your claim and update you regularly until it's resolved.

Note: You can also contact your TPA (Third-Party Administrator) or your insurance provider directly for any claim-related assistance.

WHY CLAIM THROUGH POLICYBAZAAR.AE?

At Policybazaar.ae, we understand that health insurance can feel complicated, especially when you're unwell or worried about a loved one. That's why our job is not just to help you buy the right policy, but also to stand beside you at the time of making a claim.

1. **One Point of Contact** – No need to run between the insurer, TPA and hospital. We coordinate and manage everything for you.
2. **Step-by-Step Guidance** – We explain every step in clear and simple words.
3. **Faster Resolutions** – Our dedicated claims team works to speed up the process.
4. **Help Anytime** – Whether it's a small doubt or a big issue, we are just a call away.
5. **Experience You Can Trust** – Thousands of claims successfully supported every year.

4.6 Google Rating

29K+ Reviews

1.5M+ Customers

35+ Insurer Partners

750K+ Policies Sold

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NEED ASSISTANCE?
WE'RE HERE FOR YOU

Whether you're choosing a policy, filing a claim, or just need some answers, we're here to make it easy. Reach out in the way that's most convenient for you.

Call Us: **800 800 001**

WhatsApp Us: **+971 56 145 4543**

Email Us: **care@policybazaar.ae**

Working hours:
9 AM – 6 PM GST (Mon–Sun)

Tip: For faster resolution, keep your policy number, Emirates ID and claim reference number handy when you contact us.