رؤية جديدة للتأمين
redefining insurance

Health Insurance International Treatment Request

PLEASE INFORM AXA GREEN CRESCENT WITH IN 5 WORKING DAYS PRIOR TO THE PROPOSED DATE OF TREATMENT

Date filled:

1 PATIENT INFORMATION

Patient's Name:	Patient's Card Number:	
Address:	Country:	
Mobile Number:	Email Address:	
Alternative Contact Number:	Date of Birth (dd/mm/yyyy):	
Office Number:	Fax Number:	☐ Male ☐ Female

2 POLICYHOLDER / COMPANY INFORMATION

Name of Policyholder / Company:

This service is subject to the terms and conditions mentioned in the policy wording.

3 MEDICAL INFORMATION

Please attach all **related medical reports** and **investigations.**

Diagnosis

Requested Treatment	Treatment Proposed Date: ___ /___ / _____ dd mm yyyy

4 INTERNATIONAL PROVIDER (HOSPITAL / CLINIC) INFORMATION

Name of the Hospital/Clinic:	Phone Number:
	Fax Number:
Location:	City:
	Country:

I hereby warrant the truth and completeness of all statements and authorize any Medical Attendants who have attended to me at any time to provide any health details or medical records that may be requested by AXA Green Crescent Insurance Company P.J.S.C. or their appointed representatives.

Patient's Name: Signature:	Date:

AXA Green Crescent Insurance Company P.J.S.C.
Public joint stock company with a paid-up capital of AED 200 million,
registered at the Insurance Authority with registration Nr.83
dated 16/09/2008 under Federal Law Nr.6 / 2007.