INTERNATIONAL TREATMENT REQUEST

DOC. NO. NW/INT'L01 REVISION: 1 DATE ISSUED: 09/01/19

الهلال الأخضر
green crescent
Your Health First

PLEASE INFORM GREEN CRESCENT 5 WORKING DAYS PRIOR TO THE TREATMENT PROPOSED DATE
ALL BOXES MUST BE COMPLETED IN CAPITAL LETTERS ONLY

Date Filled: _____/_____/_____
dd mm yyyy

PATIENT INFORMATION

Patient's Name		Patient's Card Number	
Address		P.O. Box	Country
Mobile Number	House Phone Number	Email Address	
Office Number	Fax Number	Date of Birth (dd/mm/yyyy)	☐ Male ☐ Female

POLICYHOLDER/COMPANY INFORMATION

Name of Policyholder/Company _____

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

MEDICAL INFORMATION

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

Diagnosis	
Requested Treatment	Treatment Proposed Date ____/____/_____ dd mm yyyy

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 GCIC or their appointed representatives.

_____ _____ Date ____/____/_____
Patient's Name Signature dd mm yyyy

Green Crescent Insurance Company PJSC
Abu Dhabi Office: P.O. Box 63323, Abu Dhabi, U.A.E. Tel. +971 2 445 8699 Fax +971 2 445 8717
Dubai Office: P.O. Box 505152, Dubai, UAE Tel. +971 4 439 1400 Fax +971 4 439 1411
www.green-crescent.com