



GLOBEMED SERVICE GUIDE

LIBANO-SUISSE TAKAFUL EGYPT

YOUR VISIT TO HEALTH PROVIDERS

What documents do I need when VISITING A **DOCTOR** WITHIN GLOBEMED NETWORK and what's the process ?

1. Your Insurance Card, if you don't have it kindly get an approval from the WhatsApp number **01066669888** or via email approvals@globemedegypt.com ,
2. Please mention the provider name and the type of consultation you need when issuing the approval .
3. Your ID or another similar legal personal document (Passport, Driver's License...)

PROCESS

- 1. Present your Insurance Card or the approval with your ID card at the doctor's office; please make sure the doctor you visit is within the GlobeMed network.
- 2. Make sure you get a **white** claim form (signed and stamped) clearly stating:
 - diagnosis code
 - prescribed medicine with treatment period
 - your personal information
 - date
 - required test.

WHAT DOCUMENTS DO I NEED TO DISPENSE ACUTE PRESCRIPTION MEDICINE ?

1. Your Insurance Card, if you don't have it kindly get an approval from the WhatsApp number **01066669888** or via email approvals@globemedegypt.com
2. Please mention the provider name and the branch when issuing the approval.
3. The **blue** copy of the claim form for **medications** fully filled and stamped by your physician, with clear reference to the date, the diagnosis and the number of packs for the duration of the treatment.

Terms:

- The medication should be purchased within **7** days maximum from the prescription date. Otherwise, the prescription is considered invalid and should need to renew the approval.

FOR CHRONIC PRESCRIPTION MEDICINE

- All you need to do is to send your chronic prescriptions and supporting documents if any to chronic@globemedegypt.com

- Below are the needed documents:
 1. A copy of the prescription or the blue version of the medical claim for explaining its appropriate diagnosis with all essential or basic details.
 2. Make sure the prescription includes the duration of treatment and the number of months of disbursement, doses, concentration and all tests.
 3. For easier communication please mention the insured member phone number.

FOR CHRONIC PRESCRIPTION MEDICINE

■ **Process:**

1. Chronic medications are posted and audited within 24 hours after sending the needed documents.
2. Medications shall be dispensed directly from the pharmacy without any prior approval each month unless you don't have your insurance card kindly send to GlobeMed for approvals.
3. Prescriptions shouldn't be older than 6 month.
4. If medication is not dispensed within 28 days, it is automatically removed from system

- After that, you only need Your Insurance Card, if you don't have it kindly get an approval from the WhatsApp number **01066669888** or via email approvals@globemedegypt.com As it will already be on the system.

WHAT DOCUMENTS DO I NEED TO RECEIVE AMBULATORY (LABS AND RADIOLOGY), DIAGNOSTIC TESTS AND/ OR PHYSIOTHERAPY SERVICES?

1. Your Insurance Card, if you don't have it kindly get an approval from the WhatsApp number **01066669888** or via email approvals@globemedegypt.com
2. The **yellow** copy of the claim form for **Labs**
3. The red copy for **radiology** tests
4. Forms should be fully filled, signed and stamped by your physician with clear reference to the date and diagnosis.
5. The green copy is for **Physiotherapy**, please make sure that your doctor specified the number of session and please be noted that you should request another approval after 12 sessions either with the same provider or not.

Terms:

- The tests should be done within **14** days maximum from the prescription date, otherwise the prescription is considered invalid and you'll need to renew the approval.

INPATIENT SERVICES

- For Cold Admissions, i.e. not emergency room admissions, you need a prior approval from **GlobeMed Egypt** via approvals@globemedegypt.com or WhatsApp number **01066669888**
- Make sure to support your request with the following documents:
 1. Medical ID Number.
 2. Medical Report specifying reason of admission or surgery required, make sure it includes the following:
 - Needed treatment, and the type of procedure
 - Name of the hospital
 - Admission date
 - Supporting documents (lab tests, radiology.. etc).
 - The medical report should not be older than one month.

WHEN OUR VALUED INSURED MEMBERS PAY IN CASH,
GLOBEMED REIMBURSEMENT DESK WILL NOT REST TILL
OUR INSURED MEMBER GETS HIS CASH BACK.

- Send to GlobeMed Reimbursement Department
- Reimbursement@globemedegypt.com
- In the next slide the reimbursement form we need for Cash Reimbursement



Reimbursement Claim Form

All fields marked with (*) are mandatory

Insured's Member's Name _____ Mobile No. * _____
 Individual # * _____ Insurance Company _____

Total Claimed Amount _____
 Number of Invoices _____

Required Approvals (Please specify the submitted documents by ticking the corresponding fields)

Outpatient Services

Medical Consultation

Original medical prescription including the insured member's name, prescriber's date and diagnosis

Original doctor's invoice or noncommercial profession invoice including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Medications

Original medical prescription including the insured member's name, prescriber's date, diagnosis, and prescribed medications

Original medications invoice detailing the price of each medication, insured member's name and date. The invoice should be stamped or in digital or electronic form.

Total Paid Amount _____

Lab Tests

Original medical report (lab test request) including the insured member's name, test's date, and diagnosis.

Copy of the lab tests results

Original invoice of the laboratory tests including the insured member's name, and date. The invoice should be stamped.

Total Paid Amount _____

X-rays

Original medical report (X-ray request) including the insured member's name, procedure's date, and diagnosis.

Copy of the X-ray results

Original invoice of the X-ray tests including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Physiotherapy

Original medical report (physiotherapy sessions request) including the lab tests results, the insured member's name, sessions' date, and diagnosis.

Original sessions record along with the date of each session

Original invoice from the physiotherapy center including the insured member's name & date. The invoice should be stamped.

Total Paid Amount _____

Inpatient Services

Original medical report detailing the reason of admission, condition upon admission along with the insured member's name, date of admission & diagnosis.

Copy of all the lab tests results performed during hospitalization.

Detailed invoice of medications and other medical items / services

Original detailed invoice from the hospital including the insured member's name and discharge date. The invoice should be stamped.

Discharge report from the hospital clarifying the condition of patient upon discharge.

Total Paid Amount _____

Additional Services

Dental Services

Original medical report including the insured member's name and service date.

Original doctor's invoice detailing the price of each service/item, tooth number, insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Optical Services

Original optometry test result including the insured member's name and date of service.

The original invoice of the eyeglasses including the insured member's name and date. The invoice should be stamped.

Total Paid Amount _____

Pregnancy and Delivery

Medical report and invoice with the amount paid, insured member's name, date, and diagnosis.

Delivery term certificate of the newborn and all the documents required for treatment within the hospital (all invoices should be detailed, separated for each service and stamped).

Ultrasound result detailing the service date and the amount paid for the ultrasound.

Total Paid Amount _____

Bank Account Details

Bank Name* _____ Beneficiary Full Name* _____
 Branch* _____ Account Number* _____

I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and / or any of my family members to provide GlobeMed Egypt with the complete information, including copies of their records with reference to my sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken in the original copy.

Client Signature and Date

SUBMIT BY EMAIL



Thank you!