Prior approval Protocols – Individual/Family Health Insurance

In case of access to a Network Provider, the Network Provider will obtain the below mentioned necessary prior approval from the Company. To facilitate this insured members should produce the OIC Health card to the Provider to identify themselves as OIC Clients. In case of non-identification to provider as OIC Clients (card not being with insured at the time of visit to provider) or in case of non-network access (within the geographical limits) the insured member should arrange for necessary prior approvals from the Company.

Prior approval of the Company is not necessary to determine eligibility of a G.P or Specialist Consultation.

No prior Authorisation is required for radiology, imaging, laboratory and other diagnostic services with the exception of MRI, CT Scans, Treadmill Stress test, Echocardiography, EEG, Endoscopic examinations, Nuclear medicine procedures. However, if the total of all outpatient procedures or tests ordered during one visit exceeds the cost of AED500/- prior approval is needed as per standard practices of Company reflected in Beneficiary User's Guide/Claim Form and respective Provider arrangements. All In-patient/ Day care treatment must be approved by the Company prior to treatments/surgical procedures being carried out. Out patient Physiotherapy as advised by the treating physician also needs prior approval of the Company.

Outpatient (consultation) treatment by visiting specialists from both inside and outside UAE is covered (provided it remains within the consultation limit as specified in this agreement). However for Minor outpatient procedures / In-patient treatment, the Company's prior approval is required and shall be payable at UAE OIC Network customary charges only.

Under pharmaceuticals, pharmaceutical treatment comprises of drugs recognized by the UAE Ministry of Health as prescription drugs and as approved by the Company as medical necessary. Prior approval is only required in the event of the prescribed dosage exceeding 15 days in case of normal illness and 30 days for Chronic conditions.

Company may require additional information relating to a treatment recommended by the provider and may assign an independent physician to give a second opinion.

Any insured member covered by more than one Insurance Scheme may not claim more than once for the same expenditure and the claim shall be subjected to Contribution as better-defined in Article 10 below.
For obtaining prior approval of the Company, the Company's representative shall be available on a 24 hour / 365 days basis, who can be contacted as follows:

During Office Hours: Phone Numbers: 04-2688323, 050-4585527; Fax Number: 04-2388323
After Office Hours: Emergency and 24 hours Help-Line: 050- 4585527
For additional client information and provider inquiry, a special cell has been formulated (CALL CENTER): 800 4746

The Company's nominated representative (On duty Medical Officer) shall respond to Policy Holders request for pre approval within 12 hours by phone and confirm the same within 24 working hours by facsimile message to the Policy Holder subject to receiving supporting facts, figures, information, reports as asked by the Duty Officer.

The Company undertakes not to unreasonably withhold according approval to pre-approval requests of the Insured Member.