

## Global health care *“ Claims form for medical expences etc. ”*

### REIMBURSEMENT PROCEDURE IN 4 STEPS :

1. You have to pay all your medical bills first (\*) and also the drugs in a pharmacy.
2. Fill out with precision the claim form and in particularly the bank details also IBAN & SWIFT.
3. Enclose the original medical bills and the original proof of payment (post receipt or e-banking print), original payment receipt from the pharmacy, original receipt from the practitioner.
4. Send to SWISSCARE to Villars-sur-Glâne.

(\*) Stationary treatment is directly paid to the hospital. Ambulatory treatment in the hospital will be handled like the step 1 to 4 above. Reimbursements are only made if the premium of the insurance is paid.

Policy No. \_\_\_\_\_

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Address \_\_\_\_\_

City/postal code \_\_\_\_\_

Country \_\_\_\_\_

Tel. \_\_\_\_\_ Fax \_\_\_\_\_

Before filling in this form, please note that the information you provide forms the basis for our processing of your claim. If there are special circumstances which are not adequately covered by the various sections of this form, please let us have the details on a separate sheet of paper, together with this form.

### Claims under Policy Section(s) (tick off)

Illness     Injury     Dental treatment

### Illness / Injury

Nature of illness / injury / diagnosis? \_\_\_\_\_

When did the injury / illness occur? \_\_\_\_\_

How long have you suffered from the illness / injury? \_\_\_\_\_

Have you previously suffered from the same illness? \_\_\_\_\_

If yes, when? \_\_\_\_\_

Have you previously received medical treatment for the same illness? \_\_\_\_\_

If yes, please state name and address of treating hospital / physician: \_\_\_\_\_

Name and address of your own general practitioner: \_\_\_\_\_

\_\_\_\_\_

**Note:** Original receipts, duly issued by attending physician, hospital or clinic, for prescriptions, medicine, medical treatment, transport by ambulance in respect of expenses, pertaining to the case must be enclosed.

\_\_\_\_\_

\_\_\_\_\_

## Compensation claimed

(Please attach original documentation)

Specification of expenses in connection with the illness /injury :	Foreign currency	EUR

Has the claim been reported to Swisscare's alarm center?      yes     no

If yes, please enter case number: \_\_\_\_\_

## Other insurance

Do you have a health insurance taken out with any other insurance company?      yes     no

If yes, please state name and address of the insurance company? \_\_\_\_\_

\_\_\_\_\_ Police nr./Policy No: \_\_\_\_\_

## Method of payment

The compensation to which you are entitled will be transferred to your bank or giro (post) account.

Name and address of the bank: \_\_\_\_\_

Bank or giro (post) account number: \_\_\_\_\_

Clearing: \_\_\_\_\_ Iban: \_\_\_\_\_

Swift (Bic) code: \_\_\_\_\_ Name and address of bank account holder: \_\_\_\_\_

## Signature etc...

I hereby accept that Nordic Health Care procures information about the state of my health with a view to obtaining the information necessary for the evaluation of the insurance event and for the assessment of the claim. My acceptance solely comprises medical reports from the date on which the policy came into force and until the final assessment date of the benefit. When supplementary medical records are issued by physicians, a special declaration is used, supplemented - at Nordic Health Care's request - with a copy or an extract of relevant case records.

The reports can be procured from authorised persons within the health care sector, hospitals and health care institutions, public authorities and insurance companies / pension funds. Other insurance companies, pension funds, and other authorised persons within the health care sector, involved in the case, are allowed to become acquainted with the medical records procured.

Insured's signature : \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ 20

[www.swisscare.ch](http://www.swisscare.ch) :    