Your International Healthcare Partner

International Private Health Insurance

HEALTH CARE CLAIM DECLARATION FORM

MEDISKY HEALTHCARE PLAN

Important Notes:

To assist us in processing your claim efficiently and speedily, please complete this form fully, clearly and legibly.
A separate claim form should be used for each patient and each medical condition.
Processing of your claim may be delayed if the information provided is incomplete.

SECTION A

INSURED PATIENT

Title Mr. / Mrs. First name & Surname												
Policy No.												
Date of Birth	**Day**			**Month**			**Year**					
Personal address												
City							**Post Code**					
Country												
E-mail												
Telephone number												

MediSky International sp. z o.o., ul. Trębacka 4, 00-074 Warsaw, Poland
T.+ 48 22 826 11 46, F.+ 48 22 826 11 46, E. office@medisky.pl

SECTION B

CLAIMS DETAILS

All fields of section B must be completed by the doctor in overall charge of the patient's treatment, or the patient himself only if there is a medical report to confirm.

Medical Practitioner's details	
Name of Practionner	
Address	
Qualifications	
Practitioner License Number (if available)	

Medical details	
Medical Diagnostic	
Onset date when symptom(s) first noticed by the patient	
When did the patient first see a doctor related to these symptom(s) ?	
Details of performed treatment(s)	
Details of performed surgical operation(s)	
Details of prescribed medication	

Hospitalization				
Hospitalization period	**Admission Date**	/ /	**Discharge Date**	/ /
Name and address of admitting Hospital **Reference number:**				
Adress				
Contact number				
E-mail				

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SECTION D

CASH BENEFIT

The hospital should complete this section if you have stayed in hospital overnight without charge, and your plan includes a Cash Benefit.

I confirm that ..... was in the hospital from …./…./…. to …./…./…. and this hospital did not charge for accommodation.

The hospital needs to stamp this claim form here:

SECTION E

PAYMENT DETAILS *(Please well noted that potential exchange rates remain at your expense)*

Who should receive payment for the claim ? (please tick one only)	**Doctor/Hospital** O	**Patient** O
Bank name		
Swift / BIC code		
Account number / IBAN		
Account name		
Currency for transfer		
Bank address		
Postcode		
Country		

SECTION F

DECLARATION

I / I confirm the facts stated on this form to be true and accurate to the best of my / our knowledge. I give authority to the insurers or their representatives to contact my / our Medical practitioners for any additional information required in connection with this claim.

Date & Signature	

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