Your International Healthcare Partner

International Private Health Insurance

CLAIM FORM

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
PATIENT DETAILS

Title Mr. / Mrs.												
Name & Surname												
Policy No.												
Date of Birth	**Day**			**Month**			**Year**					
Address												
Post Code												
Country												
Telephone												
E-mail												

MediSky International sp. z o.o., ul. Trębacka 4, 00-074 Warsaw, Poland
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SECTION B
MEDICAL DETAILS

Medical Practitioner's details

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

Onset date when symptoms first noticed by the patient	
When did the patient first see a doctor?	

Name	
Address	
Qualifications	
Diagnostic	

Details of treatment	
Details of operation	
Details of medication	

Hospital Dates	**Admission Date**		**Discharge Date**	
Name and address of admitting hospital **Reference number:**				
Adress				
Telephone				
Fax				
E-mail				

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SECTION C
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 D
PAYMENT DETAILS

Who would you like us to pay? (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 E
DECLARATION

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

Signature	
Date	

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