Reimbursement Form (Medical Part)

Please Use **BLOCK** letters to fill this form, and ensure that all sections are completed.

Section 1 - Member Information

Patient name (as printed on card)		
Patient card number		DOB
Principal name (as printed on)		
Principal contact information	E-mail:	Mobile

Section 2 - Medical Information

(To be fully completed by patient's medical practitioner - all boxes must be completed in BLOCK letters.)

Country of treatment	Provider name and contact information
Date when first symptoms were noticed	Physician name and contact information
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Physician signature and official stamp Date / /

Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s).

Symptoms:

Diagnosis:

Treatment / investigation:

Patient name	Card number

Reimbursement Form (Financial Part)

Section 3 - Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
Total claimed amount per currency:							

Section 4 - Settlement (Kindly ensure bank details are in print form)

Settlement currency:	Settlement by: ☐ Check ☐ Wire Transfer
(A) Bank name	(B) Account holder name
(C) IBAN number / Account number	(D) SWIFT code
(E) Bank address	(F) Beneficiary address

	Signature of the principal and or spouse Date: / / 20