SUPPORTED BY

CLAIM FORM
CERERE DE DESPAGUBIRE

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. PLEASE ALSO ATTACH ANY COPIES OF HISTOPATHOLOGY, ENDOSCOPIC, DIAGNOSTIC/LABORATORY TESTS WRITTEN REPORT, MEDICAL REFERRAL LETTER(S). PROCESSING OF YOUR CLAIM MAY BE DELAYED IF THE INFORMATION PROVIDED IS INCOMPLETE.

OBSERVATII IMPORTANTE: PENTRU A NE AJUTA SA PROCESAM CEREREA DVS. DE DESPAGUBIRE IN MOD EFICIENT SI RAPID, VA RUGAM SA COMPLETATI ACEST FORMULAR IN MOD INTEGRAL, CLAR SI LIZIBIL. UN FORMULAR SEPARAT DE DESPAGUBIRE TREBUIE SA FIE UTILIZAT PENTRU FIECARE PACIENT SI PENTRU FIECARE AFECTIUNE MEDICALA. VA RUGAM SA ATASATI ORICE REZULTATE HISTOPATOLOGICE, ENDOSCOPICE, TESTE DE DIAGNOSTICARE/ LABORATOR, NOTE/ RAPOARTE MEDICALE. PRELUCRAREA CERERII DVS. DE DESPAGUBIRE POATE FI INTARZIATA DACA INFORMATIILE FURNIZATE SUNT INCOMPLETE.

SECTION A / SECTIUNEA A — INSURED MEMBER / MEMBRUL ASIGURAT

TITLE
FORMULA DE ADRESARE

FAMILY AND FIRST NAME / NUME SI PRENUME

POLICY NO / POLITA NR.

DATE OF BIRTH (DD/MM/YYYY)
DATA DE NASTERE (ZZ/LL/AAAA)

PERMANENT RESIDENCE ADDRESS (To be completed only if you wish to receive your correspondence in a different address from that of the Residence Address)
ADRESA RESEDINTEI PERMANENTE (A se completa doar daca doriti sa primiti corespondenta de la noi la o adresa diferita de cea a Adresei resedintei)

CITY / ORAS

POST CODE / COD POSTAL

COUNTRY / TARA

EMAIL

MOBILE NUMBER / TELEFON MOBIL

SECTION B / SECTIUNEA B — CLAIMS DETAILS / DETALII PRIVIND CEREREA DE DESPAGUBIRE

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.

Toate campurile sectiunii B trebuie sa fie completate de medicul responsabil in general pentru tratamentul pacientului sau de pacient, doar in cazul in care exista un raport medical de confirmare.

TOTAL CLAIMED AMOUNT
VALOAREA TOTALA A CERERII DE DESPAGUBIRE

COUNTRY WHERE THE TREATMENT TOOK PLACE
TARA UNDE ATI BENEFICIAT DE TRATAMENT

MEDICAL DIAGNOSIS AND SYMPTOMS / DIAGNOSTICUL MEDICAL SI SIMPTOMELE

ONSET DATE WHEN SYMPTOM(S) FIRST NOTICED BY THE PATIENT
DATA DE APARITIE A SIMPTOMULUI/ SIMPTOMELOR (REMARCATE PRIMA DATA DE PACIENT)

WHEN DID THE PATIENT FIRST SEE A DOCTOR RELATED TO THESE SYMPTOM(S)?
CAND A CONSULTAT PACIENTUL PENTRU PRIMA DATA UN MEDIC IN LEGATURA CU ACEST SIMPTOM (SIMPTOME)?

DETAILS OF PERFORMED TREATMENT(S)
DETALII PRIVIND TRATAMENTUL (TRATAMENTELE) EFECTUAT(E)

DETAILS OF PERFORMED SURGICAL OPERATION(S)
DETALII PRIVIND INTERVENTIA (INTERVENTIILE) CHIRUGICALA(E) EFECTUATA(E)

DETAILS OF PRESCRIBED MEDICATION
DETALII PRIVIND MEDICATIA PRESCRISA

IF THE CLAIM RELATES TO PREGNANCY, IS THIS THE PATIENT'S FIRST PREGNANCY? IF NO, PLEASE DETAIL ANY PREVIOUS COMPLICATIONS OF PREGNANCY
IN CAZUL IN CARE CEREREA DE DESPAGUBIRE SE REFERA LA SARCINA, ESTE VORBA DE PRIMA SARCINA A PACIENTEI? IN CAZ CONTRAR, VA RUGAM SA OFERITI DETALII CU PRIVIRE LA ORICE COMPLICATII ANTERIOARE ALE SARCINII

YES / DA ☐
NO / NO ☐

IF THE CLAIM RELATES TO PREGNANCY, IS THE PREGNANCY A RESULT OF NATURAL CONCEPTION?
IN CAZUL IN CARE CEREREA DE DESPAGUBIRE SE REFERA LA SARCINA, ACEASTA DIN URMA ESTE REZULTATUL UNEI PROCREARI PE CALE NATURALA?

YES / DA ☐
NO / NO ☐

HAS A EUROPEAN HEALTH INSURANCE CARD (EHIC) BEEN USED
A FOST UTILIZAT UN CARD INTERNATIONAL DE SANATATE (EHIC)?

YES / DA ☐
NO / NO ☐

SECTION C / SECTIUNEA C — HOSPITALISATION / SPITALIZARE

HOSPITALISATION PERIOD / PERIOADA DE SPITALIZARE

ADMISSION DATE (DD/MM/YYYY)
DATA INTERNARII (ZZ/LL/AAAA)

DISCHARGE DATE (DD/MM/YYYY)
DATA EXTERNARII (ZZ/LL/AAAA)

HAS THE MEMBER BEEN ADMITTED THROUGH ACCIDENT & EMERGENCY (A&E) OR EMERGENCY RESPONSE (ER)?
MEMBRUL A FOST INTERNAT IN UNITATEA DE PRIMIRI URGENTE (UPU)?

YES / DA ☐
NO / NO ☐

EMAIL

CONTACT NUMBER / NUMAR DE CONTACT

If you have further treatment planned, please contact us on (+40) 311 097 046 and claims@medihelp.ro
In cazul in care sunt planificate tratamente suplimentare, va rugam sa ne contactati la (+40) 311 097 046 si claims@medihelp.ro

SECTION D / SECTIUNEA D — CASH BENEFIT / INDEMNIZATIA DE SPITALIZARE

Do you want to claim a cash benefit for treatment received free of charge?
Doriti sa solicitati o indemnizatie in numerar pentru tratamentul primit cu titlu gratuit?

☐ YES / DA ☐ NO / NU

If yes, please send confirmation of the dates of your stay or treatment with this form and proof that the services were provided free of charge.
Daca raspunsul este pozitiv, va rugam sa trimiteti datele internarii sau tratamentului dvs. Impreuna cu acest formular si dovada ca serviciile au fost prestate fara a plati vreun serviciu medical.

(Please note that potential exchange rates differences remain at your expense)
(Va rugam sa aveti in vedere ca posibilele diferente dintre cursurile de schimb valutar raman in sarcina dvs.)

SECTION E / SECTIUNEA E — PAYMENT DETAILS / DETALII DE PLATA

WHO SHOULD RECEIVE PAYMENT FOR THE CLAIM? (PLEASE TICK ONE ONLY)
CINE AR TREBUI SA PRIMEASCA PLATA AFERENTA CERERII DE DESPAGUBIRE? (VA RUGAM SA BIFATI O SINGURA DATA)

☐ DOCTOR/HOSPITAL MEDICUL/SPITALUL ☐ PATIENT PACIENTUL

SWIFT / BIC CODE / CODUL SWIFT / BIC

ACCOUNT NUMBER / IBAN / NUMARUL CONTULUI / IBAN

ACCOUNT NAME / DENUMIREA TITULARULUI CONTULUI

CURRENCY FOR TRANSFER / VALUTA PENTRU TRANSFER ☐ EUR ☐ RON

BANK ADDRESS AND NAME OF BANK / ADRESA BANCII SI NUMELE BANCII

POST CODE / COD POSTAL

COUNTRY / TARA

SECTION F / SECTIUNEA F — DECLARATION AND CONSENT / DECLARATIE SI CONSIMTAMANT

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.

☐ Confirm ca faptele prezentate in acest formular sunt veridice si exacte conform cunostintelor mele/noastre. Imputernicesc asiguratorii sau reprezentantii acestora sa imi contacteze medicii pentru orice informatii suplimentare necesare in legatura cu prezenta cerere de despagubire.

NAME
NUME COMPLET AL PERSOANEI ASIGURATE

DATE
DATA

SIGNATURE / SEMNATURA