**Private Health Insurance Claims Form**

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| **A. INFORMATION FOR THE INSURED/INSURANCE CONTRACTOR (\*\*\*only to be filled in block letters)** | | | | | | | | | | | | |
| Name and surname: | | | | | Employer: | | | | | | | |
| Policy number: | | | | | Personal identification number: | | | | | | | |
| Address: | | | Phone number: | | | E-mail: | | | | | | |
| Date of birth: | | | Gender: | | | Marital status: | | | | | | |
| **B. INFORMATION FOR THE DAMAGE REQUEST** | | | | | | | | | | | | |
| Date when the illness, injury or medical condition first occurred (MM/DD/YY): | | | | | | | | | | | | |
| Medical diagnosis after doctor examination: | | | | | | | | | | | | |
| Please describe in detail (with dates) the previous medical treatments regarding this condition (ex: medicines, consultations, operations, hospital stays): | | | | | | | | | | | | |
| Did the insured/insurance contractor have a previous chronic disease? | | | | | | | **Yes** | | | **No** | | |
| If the above answer is “yes”, describe the previous chronic disease: | | | | | | | | | | | | |
| **Did the disease or injury occurred because of:** | | | | | **Does the patient have an additional insurance:** | | | | | | | |
| a.profession of the patient: | | **Yes** | | **No** | a.other health insurance: | | | | **Yes** | | | **No** |
| b.car accident: | | **Yes** | | **No** | b.other health protection: | | | | **Yes** | | | **No** |
| c.accident: | | **Yes** | | **No** | c.third party liability auto insurance: | | | | **Yes** | | | **No** |
| If the previous answer is “yes”, please write details about the disease or injury, including the date of accident: | | | | | | | | | | | | |
| **C. INFORMATION ABOUT THE DOCTOR** | | | | | | | | | | | | |
| Name and surname of the doctor: | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | |
| Phone number: | | | | | E-mail: | | | | | | | |
| **D. DETAILED DESCRIPTION OF THE IMPLEMENTED TREATMENT, THE PRESCRIBED MEDICATIONS AND MEDICAL EXPANCES** | | | | | | | | | | | | |
| **Date (ММ/DD/YY):** | **Individual description of the services and prescribed medication** | | | | | | | **Price** | | | **Currency** | |
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| **Total amount paid by the patient:** | | | | | | | |  | | |  | |
| **Total remaining amount that needs to be paid to the healthcare institution:** | | | | | | | |  | | |  | |
| **E. INFORMATION REGARDING THE PAYMENT** | | | | | | | | | | | | |
| **Bank account number of the insured/insurance contractor:** | | | | | | | | | | | | |
| **IMPORTANT NOTICE: If the person writing this form, willingly and consciously fills it with wrong, false, or incomplete information or misinformation, may be liable for a criminal offense punishable by law and may be subject to a fine.** | | | | | | | | | | | | |
| **I the insured/insurance contractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ under full moral and material responsibility, declare, that the above answers and facts are true and correct, according to all my knowledge. I authorize my family, my personal doctor (or any other doctor who has treated me), the health care institution, pharmacy, insurance company, employer, union or association, to provide information about my health condition and previous treatments.**  **Signature\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_**  Signature Date | | | | | | | | | | | | |