CLAIM 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

FAMILY AND FIRST NAME

POLICY NO.

DATE OF BIRTH (DD/MM/YYYY)

PERMANENT RESIDENCE ADDRESS (To be completed only if you wish to receive your correspondence in a different address from that of the Residence Address)

CITY

POST CODE

COUNTRY

EMAIL

MOBILE NUMBER

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 DIAGNOSTIC AND SYMPTOMS

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

IF THE CLAIM RELATES TO PREGNANCY, IS THIS THE PATIENT'S FIRST PREGNANCY? IF NO, PLEASE DETAIL ANY PREVIOUS COMPLICATIONS OF PREGNANCY

YES

NO

IF THE CLAIM RELATES TO PREGNANCY, IS THE PREGNANCY A RESULT OF NATURAL CONCEPTION?

YES

NO

HAS AN EHIC CARD BEEN USED?

YES

NO

SECTION C HOSPITALIZATION

HOSPITALIZATION PERIOD

ADMISSION DATE (DD/MM/YYYY)

DISCHARGE DATE (DD/MM/YYYY)

HAS THE MEMBER BEEN ADMITTED THROUGH ACCIDENT & EMERGENCY (A&E) OR EMERGENCY RESPONSE (ER)?

YES

NO

EMAIL

CONTACT NUMBER

IF YOU HAVE FURTHER TREATMENT PLANNED, PLEASE CONTACT US ON (+48) 573 923 263 OR CUSTOMER-CARE@MEDISKY.PL

SECTION D CASH BENEFIT

DO YOU WANT TO CLAIM A CASH BENEFIT FOR TREATMENT RECEIVED FREE OF CHARGE?
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.

SECTION E PAYMENT DETAILS

(PLEASE NOTE THAT POTENTIAL EXCHANGE RATES DIFFERENCES REMAIN AT YOUR EXPENSE)

WHO SHOULD RECEIVE PAYMENT FOR THE CLAIM? (PLEASE TICK ONE ONLY)

DOCTOR/HOSPITAL PATIENT

SWIFT / BIC CODE

ACCOUNT NUMBER / IBAN

ACCOUNT NAME CURRENCY FOR TRANSFER

BANK ADDRESS AND NAME OF BANK

POST CODE COUNTRY

SECTION F DECLARATION AND CONSENT

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.

NAME DATE

SIGNATURE