MEDICAL EXPENSES
CLAIM FORM

***IMPORTANT**: Please ensure to submit ONE CLAIM FORM and all relative supporting documents for EACH and SINGLE DIAGNOSIS. This will greatly assist us in processing your claim. Thank you.*

INSURED DETAILS *(to be completed by the* insured*)*

LAST NAME		**FIRST NAME**	
FULL ADDRESS *(street, city, postal code, country)*			
TEL NO.	+ ( )	EMAIL ADDRESS	
DATE OF BIRTH	_____ / _____ / _____	**POLICY NUMBER**	

CLAIM DETAILS *(to be completed by the* insured*)*

BENEFIT TYPE ❒ **SICKNESS** ❒ **ACCIDENT**

For sickness only Date of first symptoms _____ / _____ / _____

❒ New medical condition ❒ Continuing medical condition

For accident only Date of accident _____ / _____ / _____

TREATMENT TYPE ❒ **OUT PATIENT** ❒ **IN PATIENT** ❒ **PHARMACEUTICALS**

For in-out patient only Date of consultation 1 _____ / _____ / __ Date of Consultation 2 _____ / _____ / _____

❒ General Practitioner ❒ Specialist: _____ ❒ X-rays ❒ Laboratory exams

❒ Dental Care / Prosthesis ❒ Other Prosthesis / Optical ❒ Medical auxiliaries

For in-patient only Date of admission _____ / _____ / _____ Date of discharge _____ / _____ / _____

MEDICAL DETAILS *(to be completed by the* Treating Doctor*)*

DIAGNOSIS (in full): _____

(Please specify hereafter further details)

❒ Medical Certificate attached *(Please tick the box if a medical certificate is available and put it together with the present claim form)*

Practitioner Signature	**Practitioner Stamp**	**Date** _____ / _____ / ____	**Insured Signature**

TREATING MEDICAL OFFICER (TMO) / REFERRING DOCTOR	
Name :	
Tel. :	
Fax. :	
Email :	
Address :	

HOSPITAL / MEDICAL FACILITIY	
Hospital Name :	
Tel. :	
Fax. :	
Address :	

SUPPORTING DOCUMENTS *(to put together with the present Claim Form)*

❒ **Original Invoice(s)** ❒ **Proof of Payment** ❒ **Prescription** (for pharmaceuticals) ❒ **Medical Referral** (for specialist)

BANK DETAIL *(to specify in the event of change since the starting date of the policy)*

Bank Name		**Branch Name**	
Account Beneficiary Name			
Bank Code		**Sort Bank Code**	
Account No.		**Key**	

Les demandes de remboursements sont à adresser à : mis SANTÉ - AVA
25 rue Maubeuge - 75009 PARIS - FRANCE
Téléphone : + 33(0) 1 53 20 44 23 - Fax : + 33(0) 1 42 85 33 69 - E-mail : extrapass@ava.fr - worldpass@ava.fr