CLAIM FORM

A duly completed claim ensures a quick reimbursement!

Before sending your claim, kindly ensure this claim form is duly filled in and that all the supporting documents are provided:

-Original invoices and receipt of payments

-Medical prescription for pharmacy, laboratory, radiology, optical expenses and series of treatment

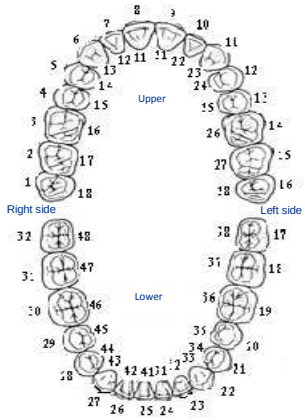
Insured		Patient	
Last name:		**Last name:**	
First name:		**First name:**	
ID / Index Number: (indicated on your card)		**Date of birth (DD/MM/YYYY):**	
Client Services Team: (indicated on your card)		**Country of care:**	
E-mail:		**I hereby authorize the Medical Department of HENNER - GMC to investigate or seek further medical information regarding this claim. I certify the accuracy of the information completed and will only request one reimbursement of the invoices attached. Misrepresentation, forgery, falsely certifying facts material to the claim, or abuse by any member will result in immediate recovery of monies and suspension and/or forfeiture of benefits.**	
Phone: (including country code)			
Country of assignment:			
Is the treatment directly related to accident? ☐ **Yes** ☐ **No** **If so, please describe the circumstances of the accident:**		**Patient's signature*:** *If the patient is a minor: a parent or a guardian. *If the patient is unable to complete/sign: his/her spouse or an adult family member.	

	Type of service	Quantity	Date of Service	Total Amount	Currency	**Diagnosis:** If possible, please use the ICD10 code
Outpatient	General Consultation					
	Specialist Consultation					
	Psychatrist consultation					
	Lab tests					
	Series of treatment, to be specified: ☐ Physical therapy ☐ Speech therapy ☐ Orthoptics therapy ☐ Other					
	Medical Imaging, to be specified: ☐ X-Ray ☐ MRI ☐ Mammography ☐ Other					
	Pharmacy, to be specified: ☐ Drugs ☐ Other ☐ Vaccines					
Other procedures (to be specified)						

				Quantity	Date of Service	Total Amount	Currency	**Correction/Diopter :** Please indicate sphere,	
Optical	Glasses	Frame							
		Lenses	Right					Right	
			Left						
	Contact lenses							Left	

	Nature of service	Quantity	Date of Service	Total Amount	Currency
Dental	Dental care				
	X-Ray				
	Periodontics				
	Dental prostheses (1)				
	Implantology (1)				
	Orthodontics				
	Other procedures (to be specified)				

(1) Please quote the treated teeth



Date (DD/MM/YYYY):
Physician/Medical Provider's seal and signature

GMCG12208 - 04/2013