

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/I	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.				
Phone: (including country code)								
Country of assignment:				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.				
Is the treatment directly related to accident?			∕es □ No	Patient's signature*:				
lf s	so, please describe the circumstand							
				*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.				
							Diagnosis:	
	Type of service		Quantity	Date of Service	Total Amou	nt Currency	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 Vaccines Other							
Other procedures (to be specified)								
`			Quantity	Date of Service	Total Amou	nt Currency	Correction/Diopter	
Optical	F	rame	Quantity	Date of Gervice	Total Alliou	in Currency	: Please indicate sphere,	
	Glasses	_enses					Right	
		Left						
	Contact lenses						Left	
	Nature of service	Quantity	Date of Service	Total Amount	Currency	(1) Please quote	the treated teeth	
Dental	Dental care						10 11	
	X-Ray					† (20) 12 U	23 12 12 pper	
	Periodontics					3 16	26 12	
	Dental prostheses (1)					² (17)17	27 (2):5	
	Implantology (1)					Right side	Left side	
	Orthodontics					32 48	31 11	
	Other procedures (to be specified)					3. 46 Lo	wer 36 19	
Date (DD/MM/YYYY):			3-042013	29 45 35 10 10 18 42 413 1 23 21 22 27 26 25 22 23				
Physician/Modical Provider's soal and signature			HENNER - Simplified Brokerage license OI	HENRER - Singified physic joint abox company - Insurance broker and Third Party Administrator - Registrate capital of 6.9.12.550 - PCS PRIOS 9.33.977.739 - Brokenage licensic ORIAS No. 07.022.039 - Regulated by the ACP (Supervisory Control Authority) - ISO 9001 conflided - Headquariess. 10 sur Henner - 79008 Pulis - France - Venue America - Proce - Venue America - Proce - Venue Authority - ISO 9001 conflided - Headquariess. 10 sur Henner - 79008 Pulis - France - Venue America - Proce - Pro				