MIS SANTÉ

MEDICAL EXPENSES CLAIM FORM

EXTRA PASS

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 : ....

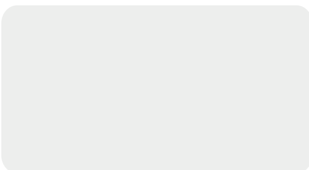
MEDICAL DETAILS *(to be completed by the* **Treating Doctor***)*

DIAGNOSIS (in full) : ....

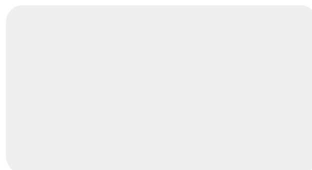
(Please specify hereafter further details)

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

Practitioner Signature

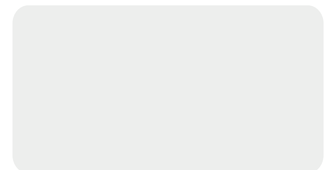


Practitioner Stamp



Date : ....

Insured Signature



TREATING MEDICAL OFFICER (TMO) / REFERRING DOCTOR

Name : ....

Tel. : ....

Fax. : ....

Email : ....

Address : ....

HOSPITAL / MEDICAL FACILITY

Hospital Name : ....

Tel. : ....

Fax. : ....

Address : ....

....

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

☐ **Original Invoice(s)** ☐ **Proof of Payment** ☐ **Prescription** (for pharmaceucals) ☐ **Medical Referral** (for specialist)

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.

Les demandes de remboursements sont à adresser à : *MIS Santé - Extra-Pass - 10 Rue Léon Paulet 13008 Marseille*