GlobalHealth

Service Center Address

Health Insurance Claim Form

Please complete page 1 of this form in BLOCK CAPITALS and ask your treating doctor/therapist to complete page 2.

All accompanying documents or invoices should preferably be in English, German, French, Dutch or Spanish and should use Arabic numerals and Latin characters (i.e. 1,2,3…/a,b,c…).

We recommend that you keep copies of all documents submitted.

Please submit this form with all other documents via your online client portal or post to our address above.

Note: Any person who knowingly and with intent to defraud, submits a claim to an insurance company containing materially false information, or who withholds, with intent to mislead, information concerning any material fact, has committed insurance fraud and thus a criminal act.

A. Main insured details

☐ Main insured is also the patient	Policy number
First name	Surname
Correspondence address	
Building name/number	Street
Postal/zip/area code AND town/city	Country AND region
Phone number (+ country code/area code)	E-mail address

B. Patient details (if different from above)

First name	Surname
Policy number	Date of birth

C. Reimbursement details

Payment method Payment by bank transfer only (account details below)	Payment currency ☐ EUR ☐ USD ☐ GBP ☐ CHF ☐ Other:
Account holder (exactly as they appear on the bank account)	Name of bank
IBAN	Postal/zip/area code AND town/city
Account number (if IBAN is not available)	Country
Swift code (BIC)	Bank branch code/routing code (BLZ, ABA, sort code – if Swift code/BIC not available)

Please note that Foyer Global Health S.A. reimburses the eligible claim amount, regardless of the currency used or the destination of the transfer. It is not necessary to be reimbursed in the same currency as your invoices. Foyer Global Health S.A. carries out all foreign currency exchanges at normal market rates and does not deduct any bank charges incurred from your reimbursement amount. Nonetheless, cross-border transfers can often incur fees from any intermediary banks involved and in some cases from your own bank as well. These fees are deducted from the final amount received, and can be quite significant. In order to avoid these charges, we recommend that if you have an account in a major currency (e.g. EUR, GBP, USD or CHF) in a respective home state (e.g. a USD account in the USA, a GBP account in the UK) you always nominate this account for reimbursement. Charges also should not apply for any EUR accounts in the SEPA Zone.

D. Patient's declaration and consent

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event this claim is found to be fraudulent in whole or in part, the policy will be rendered null and void and I will be liable for legal action. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical provider to provide any health details or medical records that may be requested by Foyer Global Health S.A. or their appointed representatives. If the patient was a minor, a parent or guardian should sign this section.

Patient's signature	Date (dd/mm/yyyy)

E. Medical provider/therapist details

Name of doctor/specialist/therapist	Qualifications/credentials
Name of hospital/clinic	
Address	
Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Phone number (+ country code/area code)	**E-mail address**

F. Medical information (to be completed by medical provider/therapist)

Patient name	Date on which patient first registered with you (dd/mm/yyyy)

Please provide full details of the medical condition requiring treatment, including the ICD code 9 or 10 (International Classification of Disease)

Patient's symptoms	Are the symptoms related to an accident? ☐ Yes ☐ No
First appearance of symptoms (dd/mm/yyyy) ☐☐☐☐☐☐☐☐	**Please indicate when the patient first consulted a doctor for the condition or symptoms (dd/mm/yyyy)** ☐☐☐☐☐☐☐☐
Please detail any tests or investigations related to this condition that were performed previously (including dates)	
Please detail any previous treatment or medication related to this condition (including dates)	
Diagnosis	
Further remarks	

Doctor's signature	Official stamp of medical provider
Date (dd/mm/yyyy)	