# CLAIMS REIMBURSEMENT FORM

## for Reimbursement of your Medical and Hospital Bills

When returning this form to the BDAE in Germany from a foreign country, please mark the envelope as follows: "MEDIZINISCHE DOKUMENTE OHNE HANDELSWERT" ("Medical Documents without any Commercial Value")

## Information on the Insured Person

| | | | |
|---|---|---|---|
| Surname | | Date of birth (dd/mm/yyyy) | |
| First name(s) | | | |
| Complete address | | Phone | |
| | | Fax | |
| | | E-mail | |

## Bank Account for Reimbursements

| | | | |
|---|---|---|---|
| Account holder | | | |
| IBAN | | | |
| BIC/SWIFT | | | |
| Account number | | BIC | |
| Bank | | | |
| Address of bank | | | |

Place, date

Signature (of the Insured Person or his or her Legal Representatives)

State: 21.10.2019

## Information on other active Health Insurance Coverage (not suspended and/or not converted to an entitlement insurance)

| | | | | |
|---|---|---|---|---|
| Does the insured person have an additional health insurance? | ☐ yes<br>☐ no | If so, please indicate as follows: | Name of insurance | |
| | | | Insurance number | |
| If you are covered by a statutory health insurance:<br>Do you have a private additional insurance for inpatient treatments? | ☐ yes<br>☐ no | If so, please indicate as follows: | Name of insurance | |
| | | | Insurance number | |
| Do you have another health or repatriation insurance with cover abroad? | ☐ yes<br>☐ no | If so, please indicate as follows: | Name of insurance | |
| | | | Insurance number | |
| Have you filed an application for reimbursement with any other office (e.g. statutory or private health insurance schemes, subsidy office)? | ☐ yes<br>☐ no | If so, please indicate as follows: | Name of insurance | |
| | | | Insurance number | |
| Start of the stay abroad of the Insured Person:<br>(dd/mm/yyyy) | | | | |

## Please observe the following guidelines in order to enable a quick and smooth settlement of claims!

**The supporting documents of the treating persons must include the following information:**

1. Name and date of birth of the person treated
2. Name of disease (diagnosis)
3. Indication of the individual services together with the respective costs
4. Dates of treatment
5. Name and address of the treating person

All supporting documents prepared in the German or English language may simply be forwarded to us. Supporting documents prepared in any other language must be accompanied by a corresponding translation.

### Invoices for pharmaceuticals

The prescription must be confirmed by the stamp of the pharmacy inclusive of the date. Please attach the respective invoice of the treating physician. If this is not possible, please have the physician stated the diagnosis on the prescription. In the event that the pharmacy issues a separate invoice for medicines, please attach the prescription to such invoice.

Nostrums (substances the composition of which has not been made public), nutriments, tonics, slimming agents and laxatives, cosmetics, mineral waters and bath additives, even if prescribed, are not regarded as medicines.

### Remedies, aids and appliances

(Please check whether these services are covered by your insurance product!)

Exclusively the applications of the physical medicine are deemed to be remedies.

Aids and appliances must always be prescribed by a specialist. Please send us the prescriptions together with the invoices, always provided that insurance coverage exists.

### Important

You are kindly asked to send us in any case the original invoices and to make copies for your files.

In case of an inpatient treatment in a hospital outside the American continent, please send us the hospital's application for assumption of costs immediately after admission to the hospital. Fax: +49-40-30 68 74-90

Thank you very much.

- Please enter the services forming the subject matter of the claim for reimbursement into the table overleaf and/or have it supplemented by the treating physician.
- You are also kindly asked to enter the data of the person treated.
- Please number the supporting documents. Do not staple or tack attachments.

State: 21.10.2019

| Surname | | Date of birth (dd/mm/yyyy) | |
|---|---|---|---|
| First name(s) | | | |

| Supporting document no. | Please describe the complaints and symptoms in your own words and state the scientific diagnosis (if possible, with the aid of your treating physician) | Occurred for the first time on | Amount |
|---|---|---|---|
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| Sum | |
|---|---|

The preceding information is true and has been given to the best of my knowledge. I have noted that intentionally false or incomplete information may result in a loss of insurance coverage and that false or incomplete information rendered with gross negligence may – depending on the severity of my fault – result in a reduction of insurance benefits, unless such information is not necessary for the determination of the insured event or the determination or volume of the insurer's duty to indemnify. The last-mentioned restriction shall not apply if the false or incomplete information has been given by me with fraudulent intent.

Place, date

Signature (of the Insured Person or his or her Legal Representatives)

State: 21.10.2019