

Your International Healthcare Partner



**International Private Medical Insurance**  
**MediSky International Plans**

# CLAIM FORM

**Important Notes:**

To assist us in processing your claim efficiently and speedily, please complete this form fully, clearly and legibly.  
 A separate claim form should be used for each patient and each medical condition.  
 Processing of your claim may be delayed if the information provided is incomplete.

## SECTION A PATIENT DETAILS

Title Mr. / Mrs.											
Name & Surname											
Policy No.											
Date of Birth	Day			Month			Year				
Address											
Post Code											
Country											
Telephone											
E-mail											



## SECTION B

### MEDICAL DETAILS

#### Medical Practitioner's details

All fields of section B must be completed by the doctor in overall charge of the patient's treatment, or the patient himself if there is a medical report to confirm.

Onset date when symptoms first noticed by the patient	
When did the patient first see a doctor?	
Name	
Address	
Qualifications	
Diagnostic	

Details of treatment	
Details of operation	
Details of medication	

Hospital Dates	Admission Date		Discharge Date	
Name and address of admitting hospital				
Reference number:				
Adress				
Telephone				
Fax				
E-mail				



## SECTION C

### CASH BENEFIT

The hospital should complete this section if you have stayed in hospital overnight without charge, and your plan includes a Cash Benefit.

*I confirm that ..... was in the hospital from ..... to ..... and this hospital did not charge for accommodation.*

The hospital needs to stamp this claim form here:

## SECTION D

### PAYMENT DETAILS

Who would you like us to pay? (please tick one only)	Doctor/Hospital <input type="radio"/>	Policy Holder <input type="radio"/>	Patient <input type="radio"/>
Bank name			
Swift / BIC code			
Account number / IBAN			
Account name			
Currency for transfer			
Bank address			
Postcode			
Country			

## SECTION E

### DECLARATION

I / We confirm the facts stated on this form to be true and accurate to the best of my / our knowledge. I / We give authority to the insurers or their representatives to contact my / our Medical practitioners for any additional information required in connection with this claim.

Signature	
Date	