SZV
Social & Health Insurances

MEDICAL REIMBURSEMENT REQUEST

INSURED INFORMATION (Please refer to your insurance card) Date received by SZV: _____

SEGURO/SZV ID NUMBER	TYPE OF SZV COVERAGE PACKAGE (TICK ONE)					
		ZV/OV		FZOG		EIL/LAND/PPK
LAST NAME	FIRST NAME(S)					
GUARDIAN's LAST NAME(If patient is a minor)	GUARDIAN's FIRST NAME					
ADDRESS (STREET, HOUSE#, DISTRICT)					HOME Tel	
EMAIL					MOBILE Tel	
BANK NAME	BANK ACCOUNT # (**REQUIRED**)					

The below section must be **FULLY COMPLETED** before your claim can be processed.

Reason why expenses were paid: (Check what is applicable)

- □ Did not have a referral letter
- □ Insurance card expired
- □ Became sick while abroad on vacation/work
- □ Specialist located on the French side
- □ Dental visit
- □ Medical treatment not available on the island
- □ Insurance card was not in my possession at the time
- □ Medication abroad
- □ House doctor was unavailable (Please explain below)
- □ Other _____

The following supporting documents MUST BE SUBMITTED as evidence to the attached claim

- × **A valid medical referral/authorization** (e.g.. a letter from your house doctor sending you to specialist.)
- × **A medical report** (e.g.. a letter from the treating doctor explaining what was done)
- × **Original receipts and a detailed specification of paid expenses**
- × **A copy of your insurance card**

INSURED SUMMARY OF CLAIM (Explain why you had to pay)

NOTE: PLEASE BE SURE TO HAVE MADE COPIES OF EVERYTHING BEING SUBMITTED FOR YOUR OWN RECORDS. PLEASE HAVE THEM ON HAND WHEN SUBMITTING SO THEY CAN BE STAMPED BY SZV AS HAVING BEEN RECEIVED, AS THE ORIGINAL RECEIPTS WILL NOT BE RETURNED.

(DENIED REQUESTS CAN REQUEST THEIR DOCUMENTATION RETURNED .)

All receipts should not be older that six (6) months and MUST indicate the following:

- **First and last name of the person submitting the claim**
- **Date or dates on which the service was obtained**
- **The service or product purchased**
- **The care provider's name, address, currency used, amount charged and amount paid.**
- **Clear proof of full payment (stamp and signature)**

RECEIPTS/INVOICES WITH INCOMPLETE OR ILLEGIBLE INFORMATION WILL BE REJECTED.

CLAIMS ARE SUBJECT TO APPROVAL FROM OUR MEDICAL DEPT PHYSICANS AND ARE CALCUALTED AND PAID ACCORDING TO GOVERNMENT REGULATED SZV TARRIFS.

CLAIM INFORMATION

Every receipt that you are submitting must be indicated with the corresponding number on the list below.

	INVOICE DATE			INVOICE DESCRIPTION Physician/Hospital/Lab/etc.	Country where it was paid	AMOUNT CLAIMED
	DD	MM	YYYY			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
					TOTAL	

ACKNOWLEDGEMENT AND CONSENT

By submitting this medical reimbursement request for processing and payment by SZV, and in consideration of SZV paying this claim, I consent and agree to the following provisions:

- The submitted services have been received and fully paid for prior to the date of this claim.
- All information contained in this claim and any supporting documents is complete and true.
- For the purpose of verifying and auditing the claim, I(we) will co-operate fully with SZV investigations.

Dated: _____ Insured signature: _____

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Dated: _____ Insured signature: _____