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		EIL/LAND/PPK		FZOG
LAST NAME	FIRST NAME(S)					
ADDRESS (STREET, HOUSE#, DISTRICT)			TEL		CEL	
EMAIL						
BANK NAME	BANK ACCOUNT #					

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

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

- □ House doctor was unavailable (Please explain below)
- □ Insurance card expired
- □ Insurance card was not in my possession at the time
- □ Became sick while abroad on vacation/work
- □ Medical treatment not available on the island
- □ Did not have a referral letter
- □ 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.

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, amount charged and amount paid.**
- **Clear proof of full payment (stamp and signature)**

RECEIPTS/INVOICES WITH INCOMPLETE INFORMATION WILL BE REJECTED.

ALL 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						
					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: _____