Please note that in the event of a claim we act on behalf of the Insurer

AMARIZ

YOUR DETAILS:

PLEASE SEND THIS FORM TO:

AMARIZ LIMITED
Imperial House
1 Harley Place
BRISTOL BS8 3JT (GB)
tel : +44 (0)117 974 5770
fax : +44 (0)117 974 5780
email : info@amariz.co.uk
www.amariz.co.uk

Client Reference:
Policy Number:

Please let us have your new address if you have moved:

……

…… Tel.: ……

Email:……

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

Please ensure you complete the following for each person claiming reimbursement on all the attached invoices (if there is not enough space, please use a blank sheet of paper):

Surname/First Name	Description of Medical Expenses/Treatment (Eg. Medication of 01.01.2019)	Type of illness and date of first diagnosis (Eg. High blood pressure since 01.12.2015)

Are any of the medical conditions indicated above long-term conditions or likely to recur? If so, which ones?

……

Please indicate if the reimbursement should be made to the provider of medical treatment ❒ or to the insured ❒

DOCUMENTS WHICH MUST BE ATTACHED TO YOUR REQUEST FOR REIMBURSEMENT:

In order to enable us to reimburse your medical expenses, you must enclose the following:

- ✓ The ORIGINAL treatment forms, invoices, prescriptions or reimbursements received from CPAM or your basic health insurance scheme or any other top-up insurance plan
- ✓ Physiotherapy: The prescription and the request for prior authorisation (10 sessions or more)
- ✓ Speech therapy: The assessment report and the request for prior authorisation (30 sessions or more)

Date and signature (compulsory)

PLEASE ATTACH YOUR BANK DETAILS IF YOU WOULD LIKE THIS AND ANY FUTURE CLAIMS TO BE PAID BY BANK TRANSFER

The Insurer needs the above medical information in order to assess whether your treatment is covered by your policy

❒ I confirm that all the persons listed above consent to the processing of their health-related personal data

REQUEST FOR DIRECT SETTLEMENT: HOSPITALISATION/HYDROTHERAPY

To enable us to pay your hospitalisation expenses directly, please complete the section below and send it to us at least 10 days before you are due to be admitted:

Name of the patient: ……

Admission number: ……

Admission date: …… Expected length of stay: ……

Name of hospital: ……

Address of hospital: ……

Telephone: …… Fax: ……

Email: ……

DOCUMENTS WHICH MUST BE ATTACHED TO YOUR REQUEST FOR DIRECT SETTLEMENT:

A **medical certificate** indicating the type of illness and the date of first diagnosis must be enclosed with your request for direct settlement. This certificate should be sent in an envelope marked 'Private and confidential – for the attention of the Consulting Doctor'. **A blank certificate is available on request or on our website.**

THIRD PARTY CLAIMS

ACCIDENT CAUSED BY A THIRD PARTY:

If you have been involved in an accident caused by a third party, please complete the following section:

Surname and first name of the insured: ……

Date of the accident: ……

Name and first name of third party : ……

Surname and first name of the third party: ……

Third party's insurer: ……

Cause and circumstances of the accident: ……

……

……

DOCUMENTS WHICH MUST BE ATTACHED FOR THIRD PARTY CLAIMS:

Please enclose a medical certificate indicating the nature of the injuries in an envelope marked 'Private and confidential – for the attention of the Consulting Doctor', as well as any other relevant documentation.

Date and signature (compulsory)

PLEASE NOTE THAT ANY INCOMPLETE CLAIM FORMS WILL NOT BE PROCESSED AS A PRIORITY AND WILL BE RETURNED TO YOU