globalhealth
Foyer Group

Claim Form

Patient

Policy Number

Patient name

Date of Birth __ /__ /____

Do you have another health or travel insurance - If yes which one? Add the policy number.

Practitioner

State briefly the nature of illness or injury (Can be ICD9 / 10 CODE)

Treatment date __ /__ /____

Description of treatment

Amount Currency

Indicate the type of condition ☐ Acute ☐ Chronic ☐ Accident

When did the symptoms first arise? __ /__ /____

What date did the patient first consults the provider for this treatment? __ /__ /____

Has the patient ever suffered from this condition before? ☐ Yes ☐ No

If YES Please provide full reports including past medical history, referral letters, investigative procedures and treatment.

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated, and I will be liable for legal action. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Foyer Global Health. or their appointed representatives. If a minor was treated, a parent or guardian should sign this section.

Date and location

...../...../..... in .....

OFFICIAL MEDICAL STAMP AND SIGNATURE(S)

Date and location

...../...../..... in .....

SIGNATURE OF THE PATIENT

*We will contact the patient if we require further information.

Foyer Global Health S.A. 12, rue Léon Laval L-3372 Leudelange, Luxembourg
service@foyerglobalhealth.com
(+352) 437 43 42 44
R.C.S. Luxembourg B134.471
TVA : LU22284578