REIMBURSEMENT APPLICATION

Please mark the basis (one of the options below) for applying for reimbursement of medical expenses:

Under contractual provisions:
- ☐ **'Freedom of Treatment' Reimbursement**
- ☐ **'The Price List' Reimbursement**
- ☐ **'Availability Standards' Reimbursement**
- ☐ **'A Friendly Transition' Reimbursement**
- ☐ **'Dental Emergency' Reimbursement**

Due to:
- ☐ **A complaint**
- ☐ **Reimbursement in the case of unavailability of a service in a given town**
- ☐ **An obtained consent for reimbursement of costs**
- ☐ **Other:**

Please send the filled-in Application along with the set of necessary documents to the following address:

LUX MED Sp. z o.o.
ul. Iłżecka 24 F
02-135 Warszawa

With a note: Refundacja (Reimbursement)

ATTENTION! The reimbursement is made in up to 3 months from the date of service provision. Please send in your documents on a vurrent basis.

_____

_____

_____

Confirmation that an attempt was made to schedule a visit at LUX MED:

Where contact was made (indicate):

- ☐ Call Centre – Phone number used for contact: _____
- ☐ Patient Portal
- ☐ Medical facility (specify the name and address): _____

Date on which contact was made: _____

Data of the Beneficiary who used the medical service:

Surname*: _____ First Name*: _____

PESEL*: _____ Date of birth: _____

Phone: _____ Mobile phone*: _____

E-mail*: _____

Company name* : _____

Forwarding address*:

Street: _____ House number: _____ Apartment number: _____

City/town: _____ Postal code: _____-_____ Post office: _____

Authorised contact person (Data of parent or legal guardian – in case of reimbursement for minors below 18 years of age)

Surname: _____ Name: _____

Phone: _____ Mobile phone: _____

E-mail: _____

Data for payment:

Bank transfer is to be made to the following account:

Bank/Branch: _____

Owner *: _____

Account number *: _____

obligatory field

Annex to Terms and Conditions No………
Status:
Restricted access document

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Data on the Healthcare services performed

1. Reimbursement is based on **original VAT invoices** issued to a natural person (the beneficiary, and in the case of children up to 18 years – the parent or guardian) together with the specification of benefits provided, including the name of the service, the quantity and the unit price of the service. The original invoice should be attached to this Application. **Reimbursement cannot be made on the basis of fiscal receipts.**

2. In the table: 'Data on Healthcare services performed' please specify the names of services provided and their price. In the event the service was a medical consultation, please enter the name of medical specialisation in the table, and when the service was a test/examination, please enter the name of the test/examination performed.

3. In the case of laboratory tests, diagnostic tests and other Healthcare services, if a referral requirement results from the Agreement (Benefitplan), and the referral for that service was issued outside an Own Facility, please attach a copy of the referral to the Application.

4. In the case of dental and rehabilitation services, you are required to attach a specification of the provided services, including the unit prices, number of provided services and nomenclature.

No	Name of service	Date on which the Healthcare service was performed	Amount	Invoice number	Reimbursement amount (filled in by LUX MED)
1					
2					
3					
4					
5					

_____
date

_____
town

_____
signature

Please remember to sign the Application

Annexes:

1. Invoices: _____ – pieces

2. Copies of referrals: _____ – pieces

3. Other:_____ – _____ pieces

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