ASSETS International Health Care Plan

MEDICAL EXPENSES CLAIM FORM

PROCEDURE FOR FILING A CLAIM

1. Please avoid making a series of small claims. It makes sense to accumulate your small medical and dental bills until you have enough to justify a significant reimbursement. Then take the precaution of making photocopies of all documents before sending the originals to Medical Administrators International.
2. Answer all questions on both sides of the claim form and attach to it the originals of all reimbursable bills. Bills should indicate name and date of birth of patient, date of treatment, a detailed description of medical services and the amount of charges corresponding to each category of treatment or service. Pharmacy bills should identify drugs purchased (name and cost per item). Bills must specify name and address of medical provider or pharmacy. Cash receipts which do not provide this information are not acceptable.
3. A bill for eyeglasses, contact lenses, prescription drugs, laboratory tests, physical therapy or chiropractic treatment must be accompanied by a copy of the doctor's prescription.
4. If a treatment costs more than 300 USD or 300 Euros, please have the physician complete and sign Section E on the claim form.
5. Fill in this claim form carefully and mail it within twelve months of treatment to:

MEDICAL ADMINISTRATORS INTERNATIONAL (ASSETS PLAN)
39, rue Anatole France
F-92300 Levallois-Perret, France

Section A – Insured Member

1. Family Name: _____ 2. First Name: _____

3. Insurance I.D. Number _____ 4. Date of Birth: _____

5. Telephone N°: _____ 6. E-mail:_____

7. Mailing Address: _____

Country: _____ Postal Code: _____

*If your bank account changed recently, please attach an account identification form and specify currency:*_____

Section B - Patients listed on this claim form

	1. Full Name	2. Relationship to Insured
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

Please complete in block letters and answer reverse side

Section C - Services / Supplies (Use one line for each health care bill)

	Date of Services (Day/month/year)	First Name of Patient	Description of Medical/Dental Services, Procedures, or Supplies	Diagnosis or Cause For Medical Service	Charges & Currency	Doctor or Location of Service
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

If any of the above is a result of an accident, please specify: ☐ Automobile ☐ Work-Related ☐ Other

A. Circumstances of accident:

B. Date and place of accident:

C. N° of bills above related to accident (*example* 1, 3, 6):

Section D – Signature

I hereby certify that the information provided is correct and true to the best of my knowledge.

Signature of Employee: Date:

Section E - Physician or provider (this section must be completed by the physician for all treatment exceeding $300 or €300)

1. Is the cause a work-related accident ? ☐ Yes ☐ No A transport accident ? ☐ Yes ☐ No
2. Diagnosis of illness or injury ?
3. History of this or any related condition with dates on which previous treatment took place:
4. Description of treatment:
5. Please print your name:

Address:

6. Telephone:
7. Fax:
8. Signature of physician:
9. Date: