Whealth International

REIMBURSMENT FORMS

*Insured No: Contract No

*Insured Name/First name

*Patient's surname (if not main insured): First Name:

*Date of treatment: * Mobile Number:

To fill up by the Medical Practitioner:

*Symptoms:

*Clinical Observation:

*Antécédents médicaux:

*Diagnostic:

*Treatment Plan:

Pharmacy: Medicine Quantity Dosage Instruction

Laboratory/Radiology: Any other procedures:

☐ Form duly filled up

☐ Medical reports.

☐ All scanned invoices and prescriptions. (Please note that the original document can be required for a period of 27 months. Keep the original with you.)

Doctor Statement

I declare to be the doctor treating the patient and certify the accuracy of the information communicated.

*Doctor's Name .....

*Doctor's Signature .....

*Doctor's Phone number .....

*Legal Stamp

Please fill in the information legibly. Copies of the same form can be used for laboratory and pharmacy care.

* Mandatory firlds

Patient Statement:

I confirm that I am the patient/spouse of the patient or the legal guardian (if the patient is under 16 years of age) and declare that all information provided is accurate. I certify the accuracy of the information on this document.

Signature: .....

Date: ... / ... / ...

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Bank Data

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To avoid any bank rejection, please send us an official bank document mentioning your bank data

Name of the Bank:

SWIFT / BIC: _____

Sort code (Only in United Kingdom:_____

Account Number:_____

IBAN_____

Name of the Account Holder:_____

Money of payment:_____

Bank Address:_____

Postal Code:_____

Town/Country:_____