

NOTICE OF HOSPITALISATION



TO: ASCORE
EXCLUSIVE HEALTHCARE CLAIMS SERVICE
30 RUE VICTOR HUGO, 92532 LEVALLOIS-PERRET cedex
SUB: HOSPITALISATION
FAX: 01 47 30 11 52

1. NAME OF POLICY HOLDER:

Nom de l'assuré:

2. POLICY NUMBER (STARTS "E"):

N° du contrat:

3. CPAM REGISTRATION NO:

N° de Sécurité Sociale:

4. NAME OF PATIENT IF DIFFERENT FROM 1.:

Nom du patient si différent de l'assuré:

5. DATE OF BIRTH OF PATIENT

Date de naissance de malade

6. DATE OF ENTRY

Date d'admission:

7. NAME AND ADDRESS OF HOSPITAL:

Nom et l'adresse de l'hôpital:

8. HOSPITAL REGISTRATION N°

N° FINESSE

9. FAX NO. OF HOSPITAL:

N° de télécopie de l'hôpital

10. TYPE OF TREATMENT (SURGERY OR MEDICAL)

Nature du traitement (chirurgie ou medical ?)

EMERGENCY ADMISSION

Entrée en Urgence

YES

OUI

NO

NON

Signature and Date:

NOTES: The above information will be required by ASCORE to process your case and make arrangements for the payment of your share of your bill directly to the Hospital. You can use this form to assemble the information before telephoning, for faxing or for posting to ASCORE.

IMPORTANT THIS INFORMATION SHOULD BE SENT TO ASCORE NOT MORE THAN TWO DAYS BEFORE THE DATE OF ENTRY

If the admission is an EMERGENCY please ask the Hospital to contact ASCORE with the above information as quickly as possible.

PLEASE WRITE CLEARLY IN CAPITAL LETTER