CLAIM FORM/ADVICE OF PENDING TREATMENT FOR MEDICAL EXPENSES

This form must be fully completed, especially Section 3, and forwarded to:

ASCORE GESTION
SERVICE INTERNATIONAL
30 rue Victor Hugo
92532 Levallois-Perret, cedex
Tel +33 (0)1 41 05 87 59

Exclusive
HEALTHCARE INSURANCE
...the helping hand

PLEASE READ THE FOLLOWING NOTES CAREFULLY:

This form is in no way an admission of liability by the Insurers.

Where payment is to be made direct on your behalf to the hospital facility, you will receive a copy of the paid invoice.

Should your claim consist of more than one incident please itemise clearly which accounts relate to each incident and the nature of your condition.

This form must be returned as soon as possible but in any event, no later than three months from the occurrence, and must be accompanied by the following documents.

- The original invoices
- Medical confirmation providing the diagnosis/nature of your condition
- **The original benefit statement 'Relève de Prestations Versées' and original invoices for any additional benefits claimed from CPAM (Complémentaires Policies only)**

1. PERSONAL DETAILS

CLAIMANT'S NAME	
ADDRESS	
PRESENT CONTACT TELEPHONE NO.	**FAX NO.**
EMAIL ADDRESS	
NATIONALITY	**DATE OF BIRTH**
CURRENT CERTIFICATE NO.	**TYPE OF POLICY**
RENEWAL DATE OF POLICY	

2. PARTICULARS OF CLAIM

DESCRIPTION OF ILLNESS/ACCIDENT:	
IF ACCIDENT, GIVE BRIEF DETAILS OF CIRCUMSTANCES:	
DATE OF ONSET OF ILLNESS OR ACCIDENT: _____/_____/_____	**IS THIS THE FIRST TIME THAT YOU HAVE SUFFERED FROM THIS CONDITION:** YES ☐ NO ☐
IF NO, PLEASE GIVE DETAILS:	
DATE OF FIRST MEDICAL ATTENDANCE: _____/_____/_____	**COUNTRY IN WHICH TREATMENT RECEIVED:**
ARE YOU INSURED AGAINST ILLNESS OR ACCIDENT WITH ANY OTHER COMPANY? YES ☐ NO ☐	**IF YES, PLEASE COMPLETE DETAILS BELOW:**
NAME OF COMPANY:	**POLICY NUMBER:**
ADDRESS:	
DETAILS OF BENEFITS:	
NAME AND ADDRESS OF USUAL MEDICAL ATTENDANT:	
	STATE CURRENCY IN WHICH YOU WOULD PREFER SETTLEMENT:

3. MEDICAL CERTIFICATE/CERTIFICAT MEDICALE

(To be completed by your treating doctor at your request / A remplir par le Généraliste à la demande du patient)

1 How long has the client been a patient of yours?
Depuis quand le client visite-t-il votre Cabinet?

2 Date of onset of illness or accident
Date du début de l'accident _____ / _____ / _____

If accident, how was the injury caused:
En cas d'accident, en préciser la cause:

If illness, give the presenting symptoms:
Si une maladie, expliquez les symptômes:

3 Date of first consultation:
Date de la première consultation: _____ / _____ / _____

4 Has the client suffered from this or any related condition previously? YES ☐ NO ☐
Le Client a-t-il déja eu ces symptômes auparavant?

If yes, please give details, including dates:
Si Oui, lesquels, et à quelle(s) date(s):

5 Has any other doctor been consulted in relation to this or any related condition previously: YES ☐ NO ☐
D'autres médecins ont-ils été consultés par rapport aux symptômes mentionés ci-dessus?

If Yes, please give details:
Si Oui, lesquels:

6 Please advise of any relevant previous medical history for this client and of any chronic condition the client may have:
Prière nous communiquer tous les antécédents médicaux de ce client, et nous dire s'il s'agit dune Maladie Chronique:

7 Diagnosis of current condition:
Diagnostic de son état actuel:

8 Full details of intended treatment and/or investigation:
Soins ou traitement/analyses proposés:

9 Name and address of hospital If client is to be an In-patient:
Nom et adresse de l'hôpital, si le client doit être hospitalisé:

Anticipated date of admission:
Date d'admission envisagée: _____ / _____ / _____

Anticipated period of hospitalisation (number of days):
Durée d'hospitalisation antcipée (nombre de jours):

Estimate of costs:
Estimation des coûts prévus: €

10 Is the client settling the bill direct? YES ☐ NO ☐
Les frais seront-ils réglés par le client?

Or will you be forwarding an invoice to us? YES ☐ NO ☐
Vous enverrez nous la facture?

11 Name of attending doctor:
Nom du Médecin Traitant:

Position / Title:
Poste:

Qualifications:
Titre ou Diplôme:

Address and telephone number:
Adresse et tel:

Signature:
Signature:

DECLARATION:

I hereby warrant the details and particulars mentioned in this form to be correct according to my information and belief. I give you permission to obtain further medical details if required from any Doctor, Hospital or Medical Authority.
Je déclare que les informations ci-dessus sont sincères et véritables à ma connaissance. Je donne l'autorisation pour que d'autres informations soient obtenues auprès de docteurs, hôpital ou autre autorité médicale.

SIGNATURE OF PATIENT / SIGNATURE DU PATIENT

DATE