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

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

LUX MED Sp. z o.o.
Al. Jerozolimskie 94
00-807 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.

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:

.....

.....

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: ..... Postal code: .....-.....

City/town:..... Post office: .....

House number:..... Apartment number:.....

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: .....

LUX MED Sp. z o.o.
Szturmowa 2 Street, 02-678 Warsaw
t: 22 450 50 05, 22 450 50 10 f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS number: 0000265353
Tax ID No (NIP): 527 252 30 80
Statistical ID No (REGON): 140723603
Share capital: PLN 676,123,500.00

Data for payment:

Bank transfer is to be made to the following account:

Bank/Branch:*: .....

Owner*: .....

Account number *:.....

**obligatory field*

Data on the Healthcare services performed:

1. Reimbursement is based on original VAT invoices or bill 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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