MEDICAL CLAIM FORM

Complete every section of this form and join the **original receipted invoices**, the copies of the prescriptions and the full **medical report** and the copy of your passport (identification + entry stamp). All these documents have to mention the patient's full name, the date of the medical treatment, the name, address and telephone number of the practitioner, the medical facility, the laboratory or the pharmacist. The receipts not providing all this information won't be sufficient (a detailed bill is required). Please, group your claims in order to avoid low amount reimbursements and take the precaution of making photocopies of all the documents before sending them to:

A.C.S. - Service médical
153 Rue de l'Université 75007 Paris, France

Certificate ID:_________________________

Family name: ____ Given name: ____

Current address: ____

Telephone: _____________________________________ E-mail: ____

The received treatment is related to:

☐ an accident, circumstances (date, place, details): ____

____

☐ an illness, diagnosis and date: ____

☐ medical or surgical history in direct or indirect relation to the medical condition concerned: ____________________________

____

☐ date of the first symptoms/signs : ____

Detail of the invoices related to medical expenses:

	Date of treatment	Country	Currency and settled amount	Treatments
1.	____________	____________	____________	________________________________
2.	____________	____________	____________	________________________________
3.	____________	____________	____________	________________________________
4.	____________	____________	____________	________________________________
5.	____________	____________	____________	________________________________

Comments: ____

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I would like to receive my reimbursement:

☐ by check in euros sent to the following address in France: ____

☐ by wire transfer to a French or foreign bank (please join complete banking details)
(Note: the transfers to a foreign account are subject to variable bank charges)

For assistance, contact Mutuaide Assistance open 24 hours a day:

- **by phone**
  33.1.45.16.43.81
- **by fax**
  33.1.45.16.63.92
  ou 33.1.45.16.63.94
- **by e-mail**
  medical@mutuaide.fr

06/2015

317 218 188 RCS Paris – S.A.S. (Simplified joint-stock company) with a share capital of € 150 000 · ORIAS N°07 000 350 – ORIAS Web site: www.orias.fr · Professional Civil Liability Insurance & Financial Guarantee in accordance with the French Insurance Code. In case of complaint, please contact ACS Complaint Service at the address above. ACS is controlled by the ACPR, 61 rue Taitbout, 75436 Cedex 9, Paris, France