SiCRED
Shoqëri Sigurimi Jete

REIMBURSEMENT FORM- B1

(For medical services which do not require the prior authorization and which are taken in medical institutions of SiCRED medical network)

Name, Father's name, Surname of the insured person: _____

Number of insurance certificate and/or number of insurance Policy: _____

SECTION 1

Type of expenses you are applying for reimbursement:

- ☐ Outpatient medical controls (internist/medical specialist)
- ☐ Diagnostic control
- ☐ Pharmaceutical expenses (please, kindly attach to this form the medical prescription and proof of payment)
- ☐ Emergency dental care
- ☐ Others (which do not require the prior authorization form from SiCRED)

Date of control / doctor's visit: _____

Date of analysis: _____

Date of medications: _____

Please, kindly attach to this form: 1) copy of insurance certificate, 2) copy of insured person ID, 3) all the original medical bills, 4) copy of any other supporting documents.

Please, kindly explain the disease/control circumstances which lead you to require medical care:

_____
_____
_____
_____

Section 2

No.	Bill	Amount/Currency	Date	Medical Institute and address
1				
2				
3				
4				
	TOTAL			

Data for the Bank Transfer: _____ _____

Bank's Name, SWIFT Code **No. of Bank Account**

I hereby declare that all the above data presented by me are fair and true. I authorized any doctor, medical institute, pharmacy, Insurer, employer or syndicate to provide SiCRED JSC with any required information which is necessary to estimate this reimbursement request. Any copy of this authorization shall be considered equal to the original.

_____ ____ / ____ / _____ ____ / ____ / _____

Signature Date Date of receipt by SiCRED

After filling this Form, please send it to the addresses:

SiCRED sh.a., Administrative Unit Nr.5, "Brigada VIII" Str., Building Nr. 3/1, Tirana, Albania

Fax: +35542237530, e-mail : contact@sicred.com.al