SiCRED
Shoqëri Sigurimi Jete

REIMBURSEMENT FORM- B2

(For medical services provided outside SiCRED medical network or for medical services taken without prior authorization from SiCRED)

INSURED PERSON DATA:

_____ _____

Name, Father's name, Surname *Number of insurance certificate and/or insurance Policy*

_____ _____

Address *Telephone/Mobile Number*

B. TYPE OF MEDICAL SERVICE AND RESPECTIVE AMOUNT FOR WHICH YOU ARE APPLYING FOR THE REIMBURSEMENT

Medical Service	Place where the services is taken	Currency	Amount
1. Inpatient			
Surgery, treatment, etc.			
Transportation to the hospital			
Intense treatment, analysis, etc.			
Prosthesis, etc.			
Medical medications			
2. Outpatient			
Outpatient surgery			
Scan resonance magnetic MRI control:			
Expenses for SCAN PET, CT, X-Ray:			
Visits, controls, to a internist, medical specialist:			
Analysis, diagnostic checks etc.			
Medical Medications:			
3. Other medical treatments:			
Sum of expenses for which you are applying for reimbursement:			

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.

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

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