



Reimbursement Application

Please mark the basis 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 **within 3 months** from provision of the services to the following address:

LUX MED Sp. z o.o.

ul. Iłżecka 24F

02-135 Warszawa

With a note: Refundacja (Reimbursement)

Due to a complaint:

- Reimbursement in the case of unavailability of a service in a given town
- 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 Entitled to Reimbursement:

Surname*: First Name*:
 PESEL*: Date of birth:
 Phone: Mobile phone*:
 E-mail*:
 Company name*:

Forwarding address*:

Street: House number: Apartment number:
 City/town: Postal code:-..... Post office:

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:

Data for payment:

Bank transfer is to be made to the following account:

Bank/Branch*:
 Owner *:
 Account number *:

*obligatory field

Annex to Terms and Conditions No.

Status:

Restricted access document





Data on the Healthcare services performed

1. Reimbursement is based on **original VAT invoices** 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.

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					
6					
7					
8					

.....
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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