MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

REIMBURSEMENT FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and fully completed form. All documents will be handled in strict confidence by our medical team. Failure to provide the required information may result in your claim not being settled. T hank you.

1 PATIENT INFORMATION

Surname		Card No.	
First Name			
Address			
Tel. No.		Fax No.	
D.O.B./Age		Email	

2 BANK DETAILS (COMPULSORY)

Account Holder Name	:	
Account Number / IBAN	:	
Bank Name	:	
Bank Address	:	
Currency	:	SWIFT Code

3 MEDICAL INFORMATION (to be completed by the Physician)

Presenting symptoms		
Date when symptoms first occurred		
Has this or any similar condition existed previously?	☐ Yes	If yes, please provide details/dates*:
Diagnostics / Investigations		
Treatments / Medications		
Provisional diagnosis		

*Please continue on a blank sheet if more space required

4 PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries /illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature: _____

Date: _____

5 PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish MSH International information with regard to any medical history, condition or services. I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature: _____

Date: _____

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