MEDICAL CLAIM FORM

Complete every section of this form and join the original invoices and the prescriptions. The fee statements and invoices have to be settled and 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 accepted.
Group your claims in order to avoid a low amount of reimbursement and take the precaution of making photocopies of all the documents before sending them to:

A.C.S.
A l'attention du service médical
153 Rue de l'Université 75007 Paris, France

Subscription n°:_______________________________

Family name: _________________________________ Given name: ____________________________________

Current address: ____

Telephone: ____________________________________ E-mail: ____

The received treatment is related to:

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

____

☐ an illness, nature of the affection:____

Details of the invoices related to medical expenses:

	Date	Country	Currency and settled amount	Treatments
1.	_____________	_____________	_____________	____
2.	_____________	_____________	_____________	____
3.	_____________	_____________	_____________	____
4.	_____________	_____________	_____________	____
5.	_____________	_____________	_____________	____

Comments: ____

____

____

I wish to receive my reimbursement as:

☐ a check in euros sent to the following address :

____

☐ a bank transfer (join coordinates)

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

• telephone	• fax	• e-mail
33.1.45.16.77.18 or 33.1.45.16.43.81	33.1.45.16.63.92 or 33.1.45.16.63.94	assistance@mutuaide.fr