OUT-HOSPITAL CLAIM REIMBURSMENT FORM

To be used for Ambulatory tests/treatments or Doctor's Visits

Patient's full name
Group's name, *if any*
Center or Doctor's name
Location *(City & Country)*
Test or Consultation date
Medical Reason
Total paid amount *in original currency*
Total claimed amount *in US Dollars*

To enclose a copy of the following:

1. Invoice
2. Receipt
3. Results of the performed tests or radiology
4. Detailed medical report from the Attending Physician
5. Access Card
6. Copy of Passport

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