MSH INTERNATIONAL

SIACI SAINT HONORE GROUP

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International Health Care Claim Form (English Version)

Erasmus+

Insured members covered by French Social Security or another basic insurance provider must first obtain reimbursement from these organizations before submitting claim forms to us. If this applied to you, please send us all copies of bills and reimbursement statements from French Social Security with a summary of reimbursements from the other insurance provider.

USEFUL TIPS

- Keep **copies of all original documents** you send to us for your own records.
- **Group your claims** to avoid small reimbursement amounts.
- **Include all original settled bills** and **medical prescriptions** indicating the illness, treatments, prescribed medication and paid amounts.
- **Request prior approval for series of treatments** (such as physiotherapy), that involve five or more sessions.
- Send in claims within 12 months of the date of treatment.
- **When submitting your first claim** or **in the event of changes to your bank account,** attach an official bank document indicating your new bank account details including: account number, name of holder, name and address of bank, IBAN (Europe), ABA number (USA), SORT code (UK) or other.

Send all documents to MSH INTERNATIONAL (see address above)

1 INSURED VOLUNTEER

Insurance n°	Last name	First name	Date of Birth (dd/mm/yyyy)
Telephone	E-mail		

	1 –Permanent address in home country	2 – Address during the mission
C/O		
House number/Street/ Apartment/ Floor		
Postal code		
City		
Country		

Address to be used for all correspondence ☐ 1 (home country) or ☐ 2 (country of mission)

Bank Details

Fill out this section carefully, indicating whether transfers are to be made to your account, the account of the host Organization or other (i.e. medical provider):

Account holder	
Name of Bank	
Complete address of bank	
Your account number (IBAN code for European accounts)	
SWIFT Code / SORT Code / BIC	
Currency	

2 MEDICAL PROCEDURES OR SUPPLIES (one line per expense)

	Date of Procedure	Description of Procedures, Services, Medical or Dental Supplies	Nature of Illness or Injury	Amount Paid	Currency	Doctor/Healthcare Establishment	Country
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

- **Were any of the procedures rendered following an accident?** ☐ yes ☐ no Circumstances of accident:

N° of procedure(s) related to accident (e.g. 2, 5, 6): Date and place of accident:

3 SIGNATURE

I hereby certify that the information provided is correct and true to the best of my knowledge. Date Signature of the member: