PassportCard

CLAIM FORM

This International Claim Form must be completed for each member in full. Kindly ask your physician or service provider to complete the information in section 2 or attach an itemized bill.

Please send the completed, signed form, including any relevant medical documents, the itemized bill, and receipts to PassportCard Deutschland GmbH via the PassportCard DE mobile app, our email address is: kundenbetreuung@passportcard.de or by post to Caffamacherreihe 8-10, 20355 Hamburg, Germany

Section | 1

1. Member's Information

Policy no.	
First Name	
Surname	

2. Claim Information

a. Describe the condition (illness, injury, or symptoms requiring treatment)

b. What is the Medical treatment received?

c. Date of treatment:

d. When did the first symptom of this condition begin?

[Within the last 30 days] [Within a few months] [More than a year ago]

e. Have you ever had or been treated for this type of illness before? [Yes] [No]

f. Are you currently taking prescription medication? [Yes] [No.] If yes, please specify

g. Is this condition caused due to an accident? If yes, complete the following:

(1) Date of accident:

(2) Location: At home / While driving / At work / Other

3. Member's Reimbursement Details

Should the reimbursement be sent to you directly, please specify the details of your bank account:

a. Name of the account holder:

b. Name of Bank:

c. Branch:

d. Account no.

4. Member's Confirmation

I hereby confirm that the information I provided herein above is correct.

Name: Signature: Date:

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Section | 2

[to be completed by the physician / provider; or attach an itemized bill]

1. Service Provider's Information

Service Provider's Name	
Specialty/Type of Provider	
Address	
Phone no.	

2. Claim's Information

a. Patient's condition: Acute / Chronic / Accident

b. Place of treatment: Clinic / Hospital (inpatient) / Hospital (outpatient) / E.R. / Lab

c. Date of treatment: _____

d. Describe the condition (including all symptoms):

_____

e. What is the diagnosis? Please also describe the treatment received (including names of suppliers, medications and prescriptions): _____

f. ICD9 and/or CPT code if available ICD CPT: _____

g. Medical history of current condition: _____

h. Recommendation for continuing treatment: _____

3. Payment Information

a. Payment received from the member: _____

b. Will you accept direct payment for the services provided? Yes / No. If yes, please attach payment information

4. Service Provider's Signature

Signature: _____ Date: _____

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