INTER
Krankenversicherung aG
Abteilung LA 581
P. O. Box 10 16 62
D - 68016 MANNHEIM

Policy no.: .....

Claim Form

Date:

Please note: if the following details are not listed on the invoice, please kindly inform about:

1) **Diagnosis or description of the sickness (please not only "treatment");**
2) **the specification of individual treatments rendered and the dates and costs thereof;**
3) **in case of purchase of medicines in the pharmacy please add a copy of the medical prescription; for eyeglasses and contact lenses the strength in dioptres has to be listed for each glass and lens;**
4) **if these details are not in English language, please kindly translate by yourself.**

No.	Family Name	First Name	Treatment Date	Remarks (such as **diagnosis/reason for treatment**)	Currency	Amount of Bill
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

Name of account holder	IBAN (International Bank Account No.)	Swift Code (or BIC)

_____ _____

Member´s Signature Date