

\*See instructions on the back.

Card no.: \_\_\_\_\_

Details of insured party

These are to be filled in by the insured party who has received medical assistance (as a patient) or their legal representative.

Full name: \_\_\_\_\_

TAX NUMBER (NIF): \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Town: \_\_\_\_\_

Province: \_\_\_\_\_

☐ Email: \_\_\_\_\_

☐ Mobile/home telephone: \_\_\_\_\_

In case of any queries regarding the reimbursement, please mark your preferred form of contact with a cross.

If you should have any queries regarding the reimbursement, you authorise us to contact (full name) \_\_\_\_\_  
holder of Identity Document no. \_\_\_\_\_.

Invoice details

No.	Bill no.	Billing date dd-mm-yy	Medical assistance item	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
TOTAL AMOUNT BILLED				

Of this amount, the insured party will be compensated with the corresponding amount in accordance with the terms of his/her policy.

Documents provided

To be filled in by the insured party. The documents may be originals or copies.

☐ Hospital discharge report (required in case of hospitalisation)

☐ Bills

☐ Prescription or medical report (if necessary)

☐ Other documents

☐ Translation of invoices

Remember no translation is required for documents in English or French.

Bank details

To be filled in if the account number is different from the account to which the premium is direct debited.

Account holder \_\_\_\_\_

Account no. IBAN 

ES

The undersigned declares that all the details on the form are true and correct and the documents provided are authentic.

Signature of the insured party or his/her legal representative

Company details

To be filled in by the company.

Receiving office code: \_\_\_\_\_

Delivering office code: \_\_\_\_\_

Entry channel:

☐ In person

☐ Registered post no. \_\_\_\_\_

☐ By post

☐ Other \_\_\_\_\_

Representative's approval (date and signature)

Receiving office (stamp and signature)

Handling office (stamp and date)

### INSTRUCTIONS FOR APPLYING FOR COST REIMBURSEMENT

- One request per insured party.
- Do not mix invoices from different insured parties in the same request.
- Fill in this document in capital letters.

**CARD No.:** take note of the 12-digit number on the Adeslas card of the insured party who has received medical assistance.

**DETAILS OF INSURED PARTY:** in this section you must fill in the full name and contact details of the insured party or his/her legal representative.

### BILLING DETAILS

You may submit the original bill or a copy.

The bill must contain the following:

- Full name or company name of the natural or legal person issuing the bill.
- Address, telephone number, official association member number and speciality.
- Tax number (NIF or CIF) of the invoice issuer.
- Detailed breakdown of the medical assistance items. In case of hospitalisation, the hospital discharge report must also be attached.
- Full name of the insured party who has received medical assistance.

### DOCUMENTS PROVIDED

The insured party must attach the original or a copy of the following documents:

- **Doctor's prescription or medical report for:**
  - Diagnosis.
  - Psychotherapy treatment.
  - Rehabilitation and physiotherapy treatment.
  - Special treatment.
  - Other services (ambulance, oxygen therapy).
- **Hospital discharge report**, in case of hospitalisation.
- **Translation of documents provided:** an official translation is required for documents in foreign languages other than English or French.

### BANK DETAILS

Your account information is required in this section. The company will pay the corresponding costs by bank transfer.

Only Spanish accounts held by the insured party making the application or the policyholder will be admitted. No payments will be made into foreign bank accounts.

If this section is not filled in, the payment will be made to the account to which the policy premium held by the insured party is direct debited.

### WHERE TO SEND THE APPLICATION

You can apply for all reimbursements simply in the private area of the website [www.adeslas.es](http://www.adeslas.es)

Also by sending this application form to P.O. box 1052, 28108 Madrid.

### HOW WE REIMBURSE YOUR COSTS

- We will contact you if we need any additional information.
- We will send you a notification when the payment order has been made.