

Procedure for submitting outpatient medical costs

for the cover "Ambucare flexible"

In order to be able to identify your mail, please be so kind as to comply with the method defined hereafter. It is important to mention the reference of your file, if known, otherwise fill in clearly section 1.

A complete and conveniently organized file contributes to a smooth handling of the file.

Documents available to you on our website: www.myglobalbenefits.aginsurance.be

The document 'Request for reimbursement of outpatient medical costs' is divided in 2 sections:

Step 1: Fill out section 1 «Identification» of the form «Request for reimbursement of outpatient medical costs».

Step 2:

Fill out, for the patient mentioned in section 1, part A till D of section 2, based on the numbered documents of proof. Please use for every insured person a separate document.

Such documents of proof are the following:

- Part A: Outpatient medical costs:

A1: Consultations, doctor visits, examinations, physiotherapy

A2: Dental Care, orthodontic treatment

A3: others (medical prostheses, hearing devices,...)

- For the costs of ambulatory care: you require your sickness fund to provide you with a review of all the subscriptions relating to the relevant person and period;
- For any subscriptions which do not figure on the previous reviews: the invoices and/or fee bills.
- For the costs of medical prostheses and hearing devices: the invoice and document of reimbursement, or certificate which confirms the refusal of intervention by the sickness fund.

- Part B: Pharmacist's costs

- For the medication, bandages,...: you will require your **pharmacist** to provide you with a «certificate of reimbursable pharmaceutical subscriptions within the framework of a complementary insurance», this is a memo which contains the patient's name and first name, the physician's name, the date of delivery, the detailed list of the products with name and price;
- Part C: optical appliances (frame of glasses, glasses, contact lenses, repairs,...)
 - Detailed invoice with a document of reimbursement provided by the sickness fund
- Part D: Dental prostheses (bridges, crowns and implants)
 - Detailed invoice with a document of reimbursement provided by the sickness fund

Please send your file to: AG Insurance - Health Care

Bd. E. Jacqmain, 53 1000 Brussels

Thank you for your cooperation

*Should you not known the group number, you may require your employer to provide you with it.



Request for reimbursement of outpatient medical costs

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■ Section	1	:	Identification
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Employer:		Group n°	:		
Employee:	Name	First Nan			
		Reference AG Insurance if known			
		Trofordio 7 a modrano manown			
IBAN/BIC :					
Patient:					
Name					<u>.</u>
First name					
Birth date	/ /				
For the patient m		per and join the documents of proof	wich fall within the cove	red period, and fill ou	it the tables below
	ery insured person a separa	ate document			
A.Medical Care)				
A.1 consultation	ons, visits, examinations	, physiotherapy, treatments,			
N°	Date	Name care supplier	Amount paid	Sickness fund	Charged to
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
				Total A 1	
A.2 dental car	e, orthodontic treatmen	t			
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
				Total A 2	
A.3 medical p	rostheses, hearing device	ces,		.0.0., (<u>I</u>
	/ /				
	/ /				
	/ /				
	1		I	Total A 3	
			Total A1 + A2 + A3	TOTAL €	

B. Pharmasist costs: medication, bandages,...(Please join the 'certificate of reimbursable pharmaceutical subscriptions within the framework of a complementary insurance')

N°	Date	Amount paid	N°	Date	Amount paid
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
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	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			Total B €	
	/ /				

C. Optical appliances (frame of glasses, glasses, contact lenses, repairs,...)

N°	Date	Nature of the costs	Amount paid	Sickness Fund	Charged to
	/ /				
	/ /				
	/ /				
	/ /				
				Total €	
				Total C1	(C1)
	/ /	Frame of glasses			
				Total C2 (MAX: 85 €)	(C2)
				Total C1 + C2	

D. Dental prostheses (bridges, crowns and implants)

N°	Date	Nature of the costs	Amount paid	Sickness Fund	Charged to
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	·			Total €	
	<u> </u>			Total D	<u> </u>

TOTAL A + B + C + D:€	

If required fill out various forms.

Please send your file to : AG Insurance - Health Care Bd. E. Jacqmain, 53

1000 Brussels

The undersigned agrees for AG Insurance to process the above-mentioned data, subject to compliance with the Belgian privacy legislation, with a view to providing and managing insurance services in general, including the drawing up of statistics. The person involved is entitled to consult and, where appropriate, to correct his data. The data relative to health shall be processed only under the responsibility of a health care professional and access thereto is limited to any such persons who need such data to exercise their duties. AG Insurance shall not communicate such data to third parties.

However, the undersigned agrees for AG Insurance to communicate such data provided it has a statutory or contractual obligation or a legitimate interest.

Signature:
Date:/
Thank you for your cooperation