



Statement of medical expenses

To be completed by health insurance company

Expenses statement number

Number of invoices

Details of name, address and domicile:

This form must be completed and sent to:

**Aevitae
Afdeling Zorgservices
Postbus 2705, 6401 DE HEERLEN
The Netherlands**

Policy number:

Contract number/Insurance Company:

In order to help with quick processing, please take into account the following points:

- We would be grateful if you could submit exclusively original invoices in the order of invoices paid and those left unpaid and preferably stapled to this expenses statement form.
- If you would like a copy of an invoice, please make a copy yourself, we will not return invoices.
- Could you please submit the invoices to us as soon as possible but in any event within 1 year after the invoice date.
- If costs have been incurred in connection with an accident we would like you to indicate this in the accident column on this expenses statement form.
- If the treatment took place abroad we would like you to indicate the invoice amount as such.
- You can download extra expenses statement forms from our website.

To be completed by the policyholder:

Invoice of (physician, establishment etc.)	Date of birth of insured	Amount of invoice in euro's	Invoice to be paid to	Accident	Abroad
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
_____	_____	_____	<input type="radio"/> Myself <input type="radio"/> Third parties	<input type="radio"/> Yes	<input type="radio"/> No
Total		_____			

Additional comments:

Date of submission: ____ - ____ - ____ You can contact me during the day via telephone number: _____

Signature: _____