Medicalia

PAYMENT REQUEST MEDICALIA

Please note: Before completing this form, carefully read the information on the back.

Please use only one payment request per health care provider.

Patient's name and first name: . . . . . .

Birth date: . . . . . .

Health insurance fund identification sticker

TO BE FILLED IN BY THE HEALTH CARE PROVIDER

ALTERNATIVE TREATMENTS (SESSIONS) Please enclose the original bill.

☐ Osteopathy or chiropractic - *8982013* ☐ Acupuncture - *8982024* ☐ Homoeopathy - *8982035* ☐ Occupational therapy - *8982046* ☐ Psychology - *8982050* ☐ Speech therapy - *8982061* ☐ Dietetics - *8982072* ☐ Remedial education - *8982083*

	Number of sessions	NIHDI code (if necessary)	Amount paid per session
1.			
2.			
3.			
4.			
5.			
6.			

EYE AND HEARING CARE

Please enclose the original bill and the prescription. (12 months max. validity)	Number	Purchase or treatment date	NIHDI code (if necessary)	Amount paid
☐ Prescription glasses – *8982094*				
☐ Contact lenses – *8982105*				
☐ Laser eye treatment - *8982116*	////////////////////		////////////////////	
☐ Keratotomy - *8982120*	////////////////////		////////////////////	
☐ Hearing aid - *8982131*				

Date : | | | | | | | | |

NIHDI registration number (if you have one)

Signature of health care provider

Stamp of health care provider

Professional association: . . . . . .

TO BE FILLED IN BY THE INSURED PERSON

PATIENT SHARE - *8982002*

☐ Affiliated outside Compulsary Insurance (SNCB, EU, etc.) or dispensation with third party payer. Please enclose the statement.

BIRTH PACKAGE - *8982142*

Name and first name of the child: . . . . . .

Birth date of the child: . . . . . .

TO BE SIGNED BY THE INSURED PERSON

I agree that the SMA MLOZ Insurance may contact my health insurance company or the National Association of Independent Health Insurance Funds directly in order to optimise my reimbursements on the basis of the data they have received in the context of the compulsory and complementary insurance.

I declare that I have been informed that in case of any false statement on my part, I will be liable to the penalties provided for by the statutes of the HIC (exclusion) and to criminal penalties. I am aware that any false statement constitutes a falsification, a fraud attempt and a fraud punishable by law.

Certified sincere and genuine,

Date and compulsory signature of the insured person:

TO BE FILLED IN BY THE POLICY HOLDER

In case of accident:	Date :	Type of accident: ☐ private life ☐ work ☐ sport ☐ school

Did you receive a compensation from another insurance?

☐ No	
☐ Yes Which one?	☐ Work accidents insurance
	☐ Private or group insurance (other than Medicalia))

Please enclose the detailed statement.

Policy holder's signature:

INSTRUCTIONS FOR THE PERSON INSURED BY MEDICALIA

Complete the part 'To be filled in by the insured person' and always sign the form. Do not forget to attach an identification sticker.

1. For alternative treatments

Please always carry a payment request with you when you have an appointment with a health care provider and let him/her complete his/her part. Please add the proofs of payment (receipt, acquittance...).

2. For eye and hearing care

If you buy glasses, lenses or a hearing aid: let the optician or audiologist fill in the payment request. Please add the medical prescription (12 months max. validity, issued before the purchase date and prescribed by an ENT specialist) as well as the invoice or a proof of payment.

If you have to undergo laser surgery or keratotomy: let the hospital's approved ophthalmologist fill in your payment request. Please also add the invoice or a proof of payment.

3. For the birth package

Complete the payment request by yourself. The birth allowance will be paid as soon as you send the birth certificate to your health insurance fund.

Justificatory documents may be sent digitally, except for doctor's notes (which must be original ones). In this case, the digital copy must be of good quality (legible) and conform to the original (no handwritten changes or alterations). We reserve the right to request the original document.

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER

- Do not complete the form if another health care provider has already done so. In that case, please fill in another payment request.
- Complete the part 'To be filled in by the health care provider', sign it and add your stamp. Please also fill in your NIHDI registration number if you have one.

REMINDER:

1. There is a general waiting period of 6 months (12 months for the birth package). If you already had a similar insurance, your waiting period could be reduced or eliminated.

2. Medicalia does not compensate for:

> drugs
> care during hospitalisation
> sessions by health care providers who are not registered with the NIHDI or who are not on our list: www.mloz.be/fr/prestataires-reconnus.
> frames nor sun glasses (with or without correction)
> dental care (including implants and prosthesis (and all corresponding advantages))
> drugs, pharmaceutical products and esthetical hospital treatments
> rejuvenating cures
> Care prescribed outside Belgium

3. All information about Medicalia is stated in the General Terms and Conditions, which you can find on www.medicalia.be

In accordance with the European Regulation of 27 April 2016 on Data Protection (GDPR), your data will be processed by the HIC MLOZ Insurance, acting as data controller for the management of your health insurance contracts. Our privacy policy is available on request by mail (MLOZ - DPO, route de Lennik 788A at 1070 Brussels) or through the following link: https://www.mloz.be/fr/privacyMLOZInsurance.

"MLOZ Insurance" health insurance company approved under code OCM/750/01 for branches 2 and 18, by the Control Office of health insurance funds and national associations.
Head office: route de Lennik 788A, 1070 Brussels - Belgium (RPM Brussels) - Enterprise number: 422.189.629.