

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.

TO BE FILLED IN BY THE HEALTH CARE PROVIDER

Patient's name

Patient's first name

Date of birth

Client number

Health insurance fund identification sticker

1. ALTERNATIVE TREATMENTS (SESSIONS)

Please enclose the original bill.	Number of sessions	Date of the sessions	NIHDI code (if necessary)	Amount paid per session
<input type="checkbox"/> Osteopathy or chiropractic - 8982013				
<input type="checkbox"/> Acupuncture - 8982024				
<input type="checkbox"/> Homoeopathy - 8982035				
<input type="checkbox"/> Occupational therapy - 8982046				
<input type="checkbox"/> Psychology - 8982050				
<input type="checkbox"/> Speech therapy - 8982061				
<input type="checkbox"/> Dietetics - 8982072				
<input type="checkbox"/> Remedial education - 8982083				
TOTAL AMOUNT PAID:				<input type="text"/>

2. EYE AND HEARING CARE

Please enclose the original bill and the prescription.	Number	Purchase or treatment date	NIHDI code (if necessary)	Amount paid
<input type="checkbox"/> Prescription glasses - 8982094				
<input type="checkbox"/> Contact lenses - 8982105				
<input type="checkbox"/> Laser eye treatment - 8982116	////////////////////		////////////////////	
<input type="checkbox"/> Keratotomy - 8982120	////////////////////		////////////////////	
<input type="checkbox"/> Hearing aid - 8982131				
TOTAL AMOUNT PAID:				<input type="text"/>

Date:

NIHDI registration number (if you have one)

Signature of health care provider

Stamp of health care provider

3. PATIENT SHARE- 8982002

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

TO BE FILLED IN BY THE INSURED PERSON IN CASE OF BIRTH PACKAGE

4. Birth package - 8982142

Name and first name of the child:

Birth date of the child:

Name and first name of the entitled person:

TO BE FILLED IN BY THE INSURED PERSON

In case of accident:	Date: <input style="width: 20px; height: 20px;" type="text"/>	Type of accident: <input type="checkbox"/> private life <input type="checkbox"/> work <input type="checkbox"/> sport
Did you receive a compensation from another insurance?		
<input type="checkbox"/> Non		
Which one?	<input type="checkbox"/> Work accidents insurance	
	<input type="checkbox"/> Private or group insurance (other than Medicalia)	
Please enclose the detailed statement.		
I accept that the compensation will be paid on another bank account than the one mentioned in my file:		
Bank account:	IBAN: <input style="width: 20px; height: 20px;" type="text"/>	
	BIC: <input style="width: 20px; height: 20px;" type="text"/>	
In the name of:	<input style="width: 20px; height: 20px;" type="text"/>	

Hereby and in order to simplify my reimbursement, I allow the HIC MLOZ insurance to ask my health insurance fund for the detailed invoice that has been reimbursed by the compulsory insurance.

Done in	on	<input style="width: 20px; height: 20px;" type="text"/>
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Signature

INSTRUCTIONS FOR THE PERSON INSURED BY MEDICALIA

- Please carry a payment request Medicalia with you when you:
 - > have an appointment with your osteopath, chiropractor, acupuncturist, homoeopath, occupational therapist, psychologist, speech therapist, dietician, or orthopedagogue, and ask the health care provider to complete their part.
 - > buy prescription glasses, contact lenses, or a hearing aid, and ask the optician or audiologist to complete their part. Do not forget to enclose the prescription.
 - > have to undergo laser surgery or keratotomy, and ask the hospital to complete the form.
- In order to benefit from the birth package, you can complete the payment request yourself.
 - > Complete the part 'To be filled in by the insured person' and sign the form. Do not forget to attach an identification sticker.
 - > Please also enclose the following documents:
 - for hearing and seeing aids: the original bill or a receipt, and the medical prescription (for glasses, contact lenses and hearing aids).
 - for the birth package: the birth allowance will be paid as soon as you send the birth certificate to your health insurance fund.

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
 - > sessions by health care providers who are not registered with the NIHDI or who are not on our list
 - > frames nor sun glasses (with or without correction)
 - > dental care (including implants and prosthesis (and all corresponding advantages))
 - > esthetical drugs, esthetical pharmaceutical products or esthetical hospital treatment
 - > rejuvenating cures
3. **All information about Medicalia is stated in the General Terms and Conditions, which you can find on www.medicalia.be**

According to the law of 8 December 1992 on the protection of privacy in relation to the processing of personal data, the data you send us will be submitted to automated processing by the HIC MLOZ Insurance (enterprise number 422.189.629, Route de Lennik 788A at 1070 Brussels) in order to handle your file correctly and for marketing purposes.

Unless you object by ticking this box , you authorize the HIC to forward your administrative data to our partners.

If you wish, you can contact the data controller at the HIC to consult, correct or delete your data, according to the law on the protection of privacy of 8 December 1992.