CLAIMS REIMBURSEMENT FORM

for reimbursement of your medical and hospital bills

When submitting medical documents from abroad by post, please always note our EORI number DE295600038415981 on the envelope.

To request reimbursement, please complete the form below.

In the event of a claim, please fill out one reimbursement form per insured person and send it to us in one of the following ways:

By post

BDAE Holding GmbH
Kühnehöfe 3
22761 Hamburg

Digital per Webupload

webupload.bdae.com

(Invoices up to max. 1.000 euros)

Digital per Service Portal

www.bdae.com/service-portal

(Invoices up to max. 1.000 euros)

Details of the insured person

Surname		Date of birth (dd/mm/yyyy)	
First name(s)			
Complete address		Phone	
		Fax	
		E-mail	

Bank account for reimbursement

Account holder			
IBAN			
BIC/SWIFT			
Account number		Bank code	
Bank			
Address of the Bank			

Place, date

Signature (of the insured person or the legal representatives)

State: 01.10.2021

Information on additional active health insurance coverage (not dormant or covered to an entitlement insurance)

Does the insured person have any other health insurance?	☐ yes ☐ no	If yes, please provide the following information:	Insurance name	
			Insurance number	
If you are covered by a statutory health insurance: Do you have private supplementary insurance for inpatient stays?	☐ yes ☐ no	If yes, please provide the following information:	Insurance name	
			Insurance number	
Do you have any other health or repatriation return insurance with foreign coverage?	☐ yes ☐ no	If yes, please provide the following information:	Insurance name	
			Insurance number	
Have you submitted another reimbursement request to another agency (e.g., statutory or private health insurance, allowance office, etc.)?	☐ yes ☐ no	If yes, please provide the following information:	Insurance name	
			Insurance number	
Start of the stay abroad of the insured person: (dd/mm/yyyy)				

For fast and smooth service processing, please adhere to the following guidelines!

The following info must be included in the receipts of the treatment providers:

1. Name and date of birth of the treated person
2. Name of disease (diagnosis)
3. The details of the individual services with the respective costs
4. Dates of treatment
5. Name and address of the practitioner

You can simply send us all receipts in German and English. For receipts in other languages, please attach a translation.

Invoices for pharmaceuticals

The prescription must be confirmed by the stamp of the pharmacy inclusive of the date. Please attach the respective invoice of the treating physician. If this is not possible, please have the physician stated the diagnosis on the prescription. In the event that the pharmacy issues a separate invoice for medicines, please attach the prescription to such invoice.

In principle, secret substances (substances whose composition is not made public), nutrients, tonics, non-prescription degreasers and laxatives, cosmetics, mineral waters and bath additives - even if prescribed - are not considered medicines.

Aids and appliances

(Please check whether these benefits are insured in your product!)

Only physical medicine applications are considered remedies.

Remedies and aids must always be prescribed by a specialist. Please send us the prescriptions together with the invoices - provided you have the corresponding insurance coverage.

Important

Invoices up to an amount of 1,000 euros can be sent to us easily and securely via our web upload or via the service portal. Please send us the original invoices for amounts of 1,000 euros or more. Always make a copy for your records.

In the case of inpatient hospital treatment, please send us a guarantee of payment from the hospital immediately after admission.
Fax: +49-40-30 68 74-90.

- Please enter the services claimed for reimbursement in the table overleaf or have the attending physician complete it.
- Please also enter the data of the treated person.
- Please number the supporting documents consecutively. Please do not staple or tack attachments.

State: 01.10.2021

Surname		Date of birth (dd/mm/yyyy)	
First name(s)			

Document no.	Please describe the complaints and symptoms in your own words and name the scientific diagnosis (if possible with the help of your treating physician)	Occurred for the first time on	Amount

Summe	

The above information has been provided truthfully and to the best of my knowledge. I have taken note of the fact that intentionally untrue or incomplete information may result in the loss of the insurance benefit, grossly negligent untrue or incomplete information may result in a reduction of the insurance benefit - corresponding to the severity of my fault - unless this information is required neither for the determination of the insured event nor for the determination or the scope of the insurer's obligation to pay benefits. The last-mentioned restriction does not apply if the untrue or incomplete information was provided by me fraudulently.

Place, date

Signature (of the insured person or the legal representatives)

State: 01.10.2021