



TRAVEL ZEN-GAPI Medical Department :
03.74.45.43.05
medical@gapigestion.com

From Monday to Friday
09:00-12:30 AM & 13:30-18:30 PM

REQUEST FOR REIMBURSEMENT

Fill in all the sections of this form and add **the original paid invoice(s) and the treatment forms** as well as medical prescriptions and medical reports. **A copy of your insurance certificate** must also be provided in order to identify your contract. Your **bank account details (Sepa Area)**. **We draw your attention on the fact that the account must be under your own name. If it is not the case, a written proxy and a copy of the ID of the owner's account as well as yours have to be sent** If the fees applied were to exceed 500 €, we would be grateful if you could send the original documents. Be careful and make a copy of every document before sending them to :

GAPI-GESTION - TRAVEL ZEN-GAPI Medical Department
Zone d'Activité ACTIBURO
99 Rue Parmentier 59 650 Villeneuve d'Ascq – France

Subscription number:

Last Name: First Name:

Postal Address:

Phone: E-mail:

The medical treatments received are related to:

Registration opened with the Assistance Company: NO YES N°:

Sickness / Accident : Circumstances (date, places, details), Diagnosis (pathology) and date:

Date of first symptoms:

Medical and Surgical History in direct or indirect link with the concerned pathology:

INVOICES DETAILS:

	Date of Medical Cares	Amount in local currency	Description of Medical Cares	Comments
1				
2				
3				
4				
5				
6				

- For any medical assistance or **Request for a direct billing by the Assistance Company in case of hospitalization**, contact Mutuaide Assistance (24/7) refer to emergency phone number on your insurance certificate
- For every request for reimbursement of fees related to ambulatory medical cares, contact TRAVEL ZEN-GAPI Medical Department by phone: 33.3.74.45.43.05 or by e-mail at: medical@gapigestion.com
- I waive the reimbursement procedures with the various health organizations to which I may be affiliated and I give subrogation to GAPI to appeal against them.**

Date:

Signature, preceded by the mention "I solemnly state that the above information is correct and does not contain any false, misleading or incomplete information"

Signature and doctor's stamp