ISIC-GAPI Medical Department:
03.74.45.43.01
medical@gapigestion.com

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

REQUEST FOR REIMBURSMENT

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 excess 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 - ISIC-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 ISIC-GAPI Medical Department by phone: 33.3.74.45.43.01 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