Overseas Health Insurance Reimbursement Claim Form

AW-
Policy number | Tariff ☐ AW24 ☐ AW-EH ☐ AW-PLUS ☐ AW24-RK ☐ AW24-DR

Information about the policyholder / the insured person

Policyholder | Host organisation

Insured person's surname | Forename | Date of birth

Insured person's address: Street, house number | Post code | Town

Telephone number | E-mail

For the AW24, AW-EH, AW-PLUS and AW24-DR tariffs

I hereby apply for the reimbursement of health costs which I have incurred.
To this end I attach **original copies** of the following:

Type	**Number**	**Amount / Currency**
Medical invoice(s)		
Medication invoice(s)		
Hospital bill(s)		
Medical aid invoice(s)		
Other receipts		

For the AW24-RK tariff

I hereby apply for the reimbursement of the remaining costs after advance benefit paid by statutory insurance.
The statement for the statutory health insurance is attached.

I was treated for:

Diagnosis

Please pay the reimbursement into the following account:

Name of the account holder

IBAN | BIC

Release from the duty of confidentiality

I hereby release doctors who are treating or who have treated me, hospitals, insurance companies, authorities and other places from their duty of confidentiality and authorise Dr. Walter GmbH/Central Krankenversicherung AG to collect all necessary information to allow them to investigate their duty to provide benefit. I confirm this by signing below.

Place, date | Signature

Please send to: Dr. Walter GmbH, Leistungsabteilung (Claims Department), Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, Germany
For queries: T +49(0)2247 9194-31, leistung@dr-walter.com