Sickness (or Accident) Claim

Only for psychologist and physiotherapist

REMEMBER TO ENCLOSE REFERRAL/ DOCTORS NOTE
NO REFERRAL/DOCTORS NOTE – NO REIMBURSEMENT

To be completed by Mølholm Forsikring
Group insurance no._____ Claim no._____

Please use BLOCK CAPITALS

Contact information to the insured party (the person who is ill or injured)

Name			CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
Address	Postcode		City/town
Tel . (work) +45	Tel . (home) +45		E-mail
Parent's Danish CPR no. (if claim is made for a child)	Name		CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
	Name		CPR no. ☐☐☐☐☐☐☐-☐☐☐☐
Company (through which you are insured):			Partner/cohabitant coverage: ☐

Details of illness/disorder/accident

1A. What is the name of the illness/disorder? What is wrong with you?

1B. When did the disorder first occur?

1C. What are your symptoms?

2. Have you previously experienced similar symptoms? Yes ☐ No ☐ When?

3.Treatment required – write X

Require psychologist **only** ☐	I have found a psychologist ☐
Require physiotherapist **only** ☐	I have found a physiotherapist ☐

4A. Are you a member of Sygeforsikringen Danmark? Yes ☐ No ☐

Insurance group no.	Membership no./Policy no.

4B. Do you have surgery coverage? Yes ☐ No ☐

Information on your own doctor (GP)

5. Name of your own doctor (GP):

6.Address to your own doctor (GP):

7. Is referral/Doctor's note enclosed? Yes ☐ No ☐
I'm e-mailing it a.s.a.p. to (webskade@behandlingsgaranti.dk): ☐ I´m sending it by fax (65 20 21 21): ☐

8. Has your own doctor referred you to a specialist? Yes ☐ No ☐ Name of specialist

Further informations and signature

9. Date of enrolment to healthcare insurance scheme (to be completed by Mølholm Forsikring A/S)

10. Bank account details for reimbursement of treatment fees	Branch code:	Account no.:

REMEMBER - The claim must be submitted no longer than 14 days after the initial treatment.

I have read the above responses and hereby declare that they are an accurate reflection of the truth. I understand that, in the event that of failure on my part to disclose information or if the responses I have given are incorrect, such that the misinformation may be of significance to the assessment of my condition of health or viability, the insurance coverage may be voided or reduced in accordance with the Danish Insurance Contracts Acts. I hereby grant Mølholm Forsikring A/S and the private hospital my permission to request details of my health prior to the date on which I was enrolled in Mølholm Forsikring A/S healthcare insurance. Medical records may be obtained from doctors, medical institutions and other insurance companies. The insurance company is also permitted to make other insurance companies and doctors aware of the information obtained.

Date	Your signature (only if you send the form as a hard copy by post)
Reserved for Mølholm Forsikring A/S	Serial no.: