GMC services
International Administration

MIP - REFUND CLAIM FORM

How to complete and send the claim?

1. Ensure you complete each item on the form to avoid a delay in the payment of your claim.

2. Ensure you sign the claim. If you are a minor/under age: have a parent or a guardian sign for you. If you are unable to complete/sign: a) have your spouse or an adult family member sign for you; or b) a United Nations officer but only if there is no spouse or adult family member present to complete/sign.

3. Have your Attending Physician or Dentist complete Part B (Attending Physician/Dentist's Statement of Services). Ensure that your Attending Physician completes each item on the form to avoid a delay in the payment of your claim. Please provide the original bills ensuring they show a) the name of the patient; b) the nature of the services rendered; c) the dates of the services rendered; and d) the detailed costs of the services rendered.

4. For drugs, optical lenses and hearing aids, do not forget to include the original prescription (unless the local health authorities require that the original prescription be retained by dispensing provider. In this case, please provide us with a copy) and the original bill paid, including the breakdown of services.

5. Your prescription for drugs should show the name of the drug, dose per day, strength and duration.

6. File a separate claim form for each family member for whom a claim is being made.

7. For your convenience, you may wish to accumulate small bills and submit them to GMC on a monthly or quarterly basis.

8. This claim form and all attachments should be submitted in a sealed envelope.
The envelope may be sent by pouch or directly by mail to the Regional Claims Administration unit in charge of your region indicated below as:

Regional Bureau for Latin America & the Carribean
Rutherfoord International Inc,
5500 Cherokee Avenue, Suite 300,
Alexandria, VA, 22312 USA

Regional Bureau for Europe & Arab States
GMC Services International Administration
10, rue Henner 75459 Paris cedex 09
France

Regional Bureau for Asia & the Pacific
GMC Services (Asia Pacific) Pte Ltd
20 Cecil Street, #05-04/05,
Equity Plaza
Singapore 049705

Regional Bureau for French speaking African countries
GMC Services International Administration
44, rue Nelson Mandela
1002 Tunis, Tunisie

Regional Bureau for English speaking African countries
GMC Services International Administration
Landmark Plaza Building, Grounds Floor
Argwings Kodhek Road
PO BOX 2745 - 00202
Nairobi, Kenya

9. Your medical expenses will be paid via direct wire transfer. You must indicate your full Bank Account details (name and address of the bank, name of account holder, account n°, S wift code, IBAN) with your Refund Claim Form. However, please note that this method of payment timeframe varies depending on the country, generally below 20 working days.

Important.
Any person who, knowingly and with intent to defraud or deceive GMC, files a claim statement containing any materially false, incomplete or misleading information will be subject to disciplinary proceedings.

Caution!
All hospitalizations must be submitted for prior agreement by GMC's Medical Advisory Board before admission. The Prior Agreement Form, available on United Nations/GMC website, must be sent on a confidential basis no later than 10 working days prior to the scheduled admission date.

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Part A: To be completed by the subscriber

Subscriber				If the patient is not the subscriber			
Last name:		First name:		Last name:		First name	
GMC ID :				Date of birth (DD/MM/YY):	/ /		
Phone :		Fax :					
E-mail:							

Is the present illness or injury a result of an accident?	Yes		No	If yes, please enclose details (e.g. describe circumstances, etc.)
Is a third party responsible?	Yes		No	If yes, please enclose details (e,g, name, address, etc.)
Is the present illness or injury considered to be work related?	Yes		No	If yes, please enclose details (e.g. describe the circumstances, etc.)

Please give full details of the bank account to which the claim reimbursement should be made

Full name of account holder:	
Name and address of bank:	
Account number:	
Branch number:	
Swift code:	
IBAN code:	

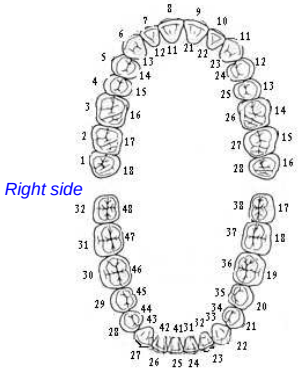
Part B: To be completed by the attending physician/medical provider [1]

Please attach all supporting documents (medical prescription, invoices and receipts...)

Diagnosis:

Outpatient care		Date of Service	Quantity	Total Amount	Currency		
C / CS / CN	Physician consultation						
	I hereby attach the detailed original bills showing the dates of service and the name of the patient					Yes	No
Z3	X-Rays						
	I hereby attach the medical prescriptions and the detailed original bills showing the dates of service and the name of the patient					Yes	No
ZM	Mammography						
	I hereby attach the medical prescriptions and the detailed original bills showing the dates of service and the name of the patient					Yes	No
B	Lab tests						
	I hereby attach the medical prescriptions and the detailed original bills showing the dates of service and the name of the patient					Yes	No
PHN	Pharmacy						
	I hereby attach the medical prescriptions and original detailed invoices with the breakdown of expenses per drug					Yes	No
VAC	Immunizations						
	I hereby attach the medical prescriptions and original detailed invoices with the breakdown of expenses per vaccine					Yes	No
Other procedure							
	I hereby attach the detailed original bills showing the dates of service, the name of the patient and the breakdown of expenses					Yes	No
Medical prostheses							
OR	Hearing aids/orthopaedic prostheses (to be specified)						
	I hereby attach the medical prescriptions and original detailed invoices					Yes	No
Optical care							
VER	Glasses						
LEN	Contact lenses						
MYO	Lasik surgery						
	I hereby attach the medical prescriptions and original detailed invoices with the breakdown of expenses					Yes	No

Dental care		Teeth #	Date of Service	Quantity	Total Amount	Currency
SC	Dental treatment (details required)					
PD	Dental prostheses					
TO	Orthodontics					
Other procedure (to be specified)						



Please circle tooth/teeth treated on chart

I hereby attach the detailed original bills showing the dates of service, the name of the patient and the breakdown of expenses	Yes	No

Date (DD/MM/YY): / /	I hereby authorize GMC to investigate or seek further information regarding this claim in accordance with the rules of the United Nations MIP.	Patient's signature*
Physician/Medical Provider's seal and signature		(*If the patient is a minor: a parent or a guardian. If the patient is unable to complete/sign: a) his/her spouse or an adult family member; or b) a United Nations officer but only if there is no spouse or adult family member present to complete/sign).

[1] Alternatively, instead of completing part B of the form by your physician, original bills with receipts may be submitted provided they show a) the name of the patient; b) the nature of the services rendered; c) the date of the services rendered; and the d) the detailed costs of the services rendered.