

REPAYMENT FORM

Deutsche Krankenversicherung AG
Department LGR7D
Post office

40198 Düsseldorf

Insurance number: AR50 000 168.....
Policy holder: Fulbright

Name of insured
(Name, first name) Date of birth
 male
 female
(Address/Telephone)

I hereby request the repayment of the costs I have incurred due to illness. For this purpose I/we am/are enclosing the following (number of)

- Doctor's invoice(s)
- Pharmaceutical invoice(s)
- Hospital invoice(s)
- Medical aid/remedy invoice(s)
- other cost receipts

I was treated for: (Diagnosis)

I request repayment into my following account:

Account owner
Account No.
BLZ
Bank

I hereby release doctors who are treating me, respectively have treated me, hospitals, as well as insurance companies, authorities and other offices from their professional secrecy and give DKV Deutsche Krankenversicherung AG authority to gather all necessary information to check their obligation of rendering service.
I confirm this with my following signature.

Date

Signature

