DEPARTMENT OF HEALTH

MALTA

Cross Border Care,
National Contact Point
Tel: 22992381 email: crossborderhealth@gov.mt

CLAIM FORM FOR REIMBURSEMENT OF TREATMENT / HEALTH CARE SERVICE(S) SOUGHT UNDER CROSS-BORDER Regulations

Section 1: Patient Details			
Surname:		Gender:	☐ Male ☐ Female
Name:		Date of birth:	
I.D. No.:		Tel. No.:	
Email:		Mobile No.:	
Address:	Permanent residence address in Malta	Alternative address for correspondence	
Is the patient entitled to healthcare from the Public Health Care System in Malta? ☐ Yes ☐ No		National Insurance No.:_____	

Section 2: Health Care Service/s	
What is the **diagnosed** medical condition for which the patient has received treatment abroad? (as documented in attached medical summary)	
Was prior authorisation of treatment sought?	☐ Yes ☐ No

Details of the health care service(s) / treatment(s) received abroad:		
Treatment Abroad	**Please specify**	**Dates health care received**
Investigations (e.g. blood tests / scans)		
Consultation		
Intervention(s)		
Medication/drug(s)		
Length of stay in health care facility		

*Member State where patient is entitled to Health Care

**Competent Institution: responsible for the publicly funded national health care system

What is the reason you sought treatment abroad?	
Do you require follow-up treatment in Malta?	☐ Yes ☐ No

Section 3: Details of Health Care Provider(s) where patient received treatment			
Name of health care facility:			
Name of treating clinician:			
Address of Health Care Facility:			
Country:			
Telephone number:			
Email address:			
The health care provider is in the:		☐ Public Sector	☐ Private Sector
Where you satisfied with the service and quality of the health care service(s) received abroad?		☐ Yes ☐ No	If No, why?
If medications/drugs were prescribed and dispensed:			
Name of Pharmacy that dispensed drugs:			
Address of Pharmacy:			
Country			
Telephone number			
Email address			

Section 4: Expenditure for which reimbursement is being claimed			
Date of receipt	Establishment paid	Treatment covered	Receipt amount paid
Total number of Original receipts (proof of payment) submitted with this form:			

Section 4: Attachment of Required Documentation	
☐Yes	Ticket of referral: a ticket of referral from the patient's clinician, indicating the patient's medical condition(s)/diagnosis, time-line of events and the medical need for the treatment prior to it being sought, must be attached. This needs to be done by a Specialist (as per Specialist Accreditation Register) if prior authorization is sought
☐Yes	Medical Summary: a letter/report from the health care facility where treatment was received must be attached. This should include a description of the treatment(s) received, date(s) treatment(s) was received, any diagnostic tests performed and any medication/drug(s) used as part of the treatment.
☐Y ☐ N	Copy of Schedule V form (yellow card) (if applicable)
☐Yes	Original itemised receipts

Section 5:Declaration and Signature(s)		
☐	I declare that to the best of my knowledge all the information given in this form is correct and complete.	
☐	I understand that the Department of Health is not liable for health care received abroad under the Cross border directive.	
☐	I understand that reimbursement of eligible treatment costs are up to the amount as costed by the Public Health Care System in Malta, or the actual cost of the healthcare service received, whichever is the lowest, and does not include travel, accommodation or any other additional expenses.	
☐	I confirm that I am not in receipt of reimbursement for the above mentioned health care service(s) from any other source.	
……..... Patient's signature	_____ Date	……..... Signature of Parent / Legal Guardian / Custodian of minor or if incapable of taking care of his/her own affairs
……..... Full Name and Surname (block letters)	_____ I.D. number of signatory	……. Full Name and Surname (block letters)
		……. Relation to patient.

OFFICE USE:

Case No_____ Officer receiving form_____ Date:_____

Reimbursement: ☐ Yes ☐ No