REIMBURSEMENT CLAIM

Document which MUST be included
(Send only one form at a time even if medical expenses concern several family members)

This document must be correctly completed by the beneficiary.

Main beneficiary	*First name*	*ACI Contract No.*

Telephone	*Email*

SUPPORTING DOCUMENTS REQUIRED (non exhaustive list):

HOSPITALISATIONS AND MATERNITY:

Hospitalisations are subject to prior agreement (document available) to be sent by fax to (33) 4 50 02 05 65 or by email to the following address service.medical@bil-assurances.fr.

Direct payment to the healthcare institutions can be organised to avoid any advance fees. Warning: Some healthcare institutions do not accept advance fees.

MEDICAL COSTS AND OPTICAL:

Consultations: Attach the receipt from the practitioner.

Pharmacy, analyses, radiology, etc...: Attach the medical prescription and the detailed and paid invoice from the practitioner, the laboratory....

DENTAL:

Treatment: Attach the detailed and paid invoice (treatment and teeth involved).

Dentures and orthodontics: Dental treatment are subject to prior agreement (document available) to be sent by fax to (33) 4 50 02 05 65 or by email to the following address frais-de-sante@bil-assurances.fr.

The medical fees will be reimbursed on presentation of paid and detailed invoices, specifying the teeth concerned by the use of dentures and the semester for orthodontics.

PHYSIOTHERAPY, SPEECH THERAPY AND ORTHOPTICS:

Series of treatment subject to prior agreement (document available) to be sent by fax to (33) 4 50 02 05 65 or by email to the following address frais-de-sante@bil-assurances.fr.

IMPORTANT NOTE:

TREATMENT RECEIVED INFRANCE Ask your practitioner for the CERFA document (brown and white sheet) or an equivalent document. The medical prescription must also be included. These documents are required for your claim.

MEDICAL PRESCRIPTIONS: Medical prescriptions must be established on an authorised document stating name and date of birth of the patient and including the practitioner's signature and stamp.

FOR ALL QUESTIONS REGARDING YOUR REIMBURSEMENT
CONTACT OUR MANAGEMENT CENTRE

Telephone: (33) 4 50 88 10 09 ***Email:*** frais-de-sante@bil-assurances.fr

LISTE OF TREATMENT RECEIVED

Date	Last name - Patient's first name	Treatment	Amount paid

I certify that the information provided on the reimbursement claim is complete and accurate and that I have neither included or omitted information that might mislead the Insurer, being understood that incomplete or inaccurate information may lead to the application of Article L 113-8 (contract void) or L 113-9 (reduced reimbursement) of the French Insurance Code, or the application of articles L.221-14 and L.221-15 of the French Code de la Mutualité (Mutual societies code). I agree to provide the insurer with the required information concerning the beneficiaries in strict compliance with the current legislation on the processing of personal data. This information may be provided to authorised professional bodies and to all those involved in the management and execution of this contract. I have the right to access and correct my personal data with the CNIL Correspondent for each Insurer, whose addresses are specified in the information note.

Please return this document together with the original receipts to the following address: **ACI Gestion** **BP 35** **74270 FRANGY** **France**	Signature of the main beneficiary: