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**Annex 7**

## MEDICAL EXPENSES FORM

Reference/Claim-file no.:……
Date of accident: ……..
Place of accident: …….
First name and last name of patient: ……

| Item no. | Date | Amount paid | Amount paid by mutual health-insurance provider | Amount paid by other insurers | Balance payable |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |

**IMPORTANT: Where possible, please number and enclose all items (e.g. medical certificates completed by the doctor and the mutual health-insurance provider, hospital invoices, BVAC certificates or other documentation from your pharmacist in respect of medication supplied).**

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