REFUND APPLICATION FORM

PLEASE MAKE THE REFUND OF THE COSTS OF THE FOLLOWING SERVICE:

Note: please specify the full name of the service provided. Examples: endocrinologist consultation, nipple biopsy, removal of skin lesions - electrocoagulation, 2 lesions.

PROVIDED FOR:

Full name of the patient

Patient's PESEL number or date of birth for foreigners

Telephone number of patient/guardian

Patient's address

AT THE FACILITY:

Full name of the facility

Address of the facility

Date

The service has to be invoiced because

The cost of the service as specified on the invoice was PLN (incl.).

At the same time, I confirm that I am aware of the conditions for refund of the costs of the provided service that has been invoiced:

- the service is included in the patient package;
- the service specified on the invoice was reported to the enel-med call centre;
- the service was provided within days from the date of receipt of the consent from the enel-med call centre;
- the refund of the service cost does not exceed the limit agreed with the enel-med call centre;
- in the case of medical consultations, diagnostic tests, laboratory tests, dentistry, rehabilitation services, a detailed list of the services provided (including unit prices) is attached (either included in the invoice or attached to this application form);
- the invoice is made out to the name of a patient or legal guardian (a simplified invoice is not accepted);
- the invoice was sent to the e-mail address: wnioski-swobodaleczenia@enel.pl in the form of a readable scan, within a maximum of 2 months from the date of service provision.

Note: all the above conditions must be met cumulatively. Failure to meet one of them will result in the rejection of the reimbursement application.

THE REFUND IS MADE ONLY BY BANK TRANSFER TO A BANK ACCOUNT

(Only bank transfer is allowed – we cannot provide any other form of reimbursement, e.g. by cash or postal order). Please fill in the details below.

Bank account number

Bank name

Account holder

Account holder's address

Town and date

Legible signature of the patient

Legible signature and card number of a legal guardian (in case of an underage patient)