StarzHealth Reimbursement Form

Important: Please complete all sections and attach original receipts & medical reports for prompt reimbursement.

Section 1: Member Details

Full Name:

_____

Insurance Card Number:

_____

Date of Birth:

_____

Contact Number:

_____

Email:

_____

Residential Address:

_____

Section 2: Policy Information

Policy Number:

_____

Employer Name (if applicable):

_____

Coverage Type (Individual / Family / Corporate):

_____

Section 3: Treatment Details

Date(s) of Treatment:

_____

StarzHealth Reimbursement Form

Clinic/Hospital Name:

_____

Doctor's Name:

_____

Diagnosis:

_____

Treatment Provided:

_____

Currency:

_____

Section 4: Reimbursement Request

Total Amount Paid:

_____

Bank Name:

_____

IBAN:

_____

Account Holder Name:

_____

Swift Code (if applicable):

_____

Section 5: Document Checklist

- Original medical invoices & receipts
- Doctor's prescription / medical report
- Copy of insurance card
- Any referral letters (if applicable)

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- Passport copy (for overseas treatment)

Section 6: Declaration

I confirm that the above information is accurate and complete. I understand that falsifying information may result in denial of reimbursement and possible legal action. I authorize StarzHealth to process this request and verify details with relevant parties.

Signature: _____

Date: _____