Your belief, our responsibility

CAMBODIA-VIETNAM INSURANCE PLC.
8th Floor, No. 398, Monivong Blvd., Boeng Keng Kang I,
Boeng Keng Kang, Phnom Penh, Cambodia.

REIMBURSEMENT FORM

To help us process your claim promptly, please provide the medical report, original invoice/s and fully completed form.
All documents will be handled in strict confidence by our medical team.
Failure to provide the required information may result in your claim not being settled. Thank you.

1 PATIENT INFORMATION

Surname	:		
First Name	:		
Address	:		
Tel. No.	:	Fax. No.	:
D.O.B. / Age	:	Email	:

2 BANK DETAILS (COMPULSORY)

Account Holder Name	:		
Account Number / IBAN	:		
Bank Name	:		
Bank Address	:		
Currency	:	SWIFT Code	:

3 MEDICAL INFORMATION (to be completed by the Physician)

1. Chief medical complaints:

2. When has the patient first noticed the symptom(s)?

3. What is the final diagnosis and the cause of the condition?

4. Has this condition been triggered by underlying pathologies?
☐ No ☐ Yes, please specify:

5. From a medical standpoint, when do you think this condition may have started?

6. Has patient been treated earlier and then referred to you?
☐ No ☐ Yes, please provide the name of hospital/clinic or the referring doctor:

7. Recommended treatment plan:

*Please continue on a blank sheet if more space is required

4 PHYSICIAN DECLARATION

I hereby certify that I have personally examined and treated the insured for his/her injuries/illness described above and that the facts stated above represent my medical opinion of his/her condition.

Signature : _____

Date : _____

Stamp

5 PATIENT DECLARATION

I hereby authorize the Physician, Hospital, Laboratory, Pharmacy, or any person who has provided medical services to me to furnish CVI information with regard to any medical history, condition or services. I confirm that all information provided by myself in relation to this claim is true and correct, and no material facts have been withheld.

Signature : _____

Date : _____

Hospital Contact (24/7)
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