

INTERNATIONAL ORGANIZATION FOR MIGRATION MEDICAL SERVICE PLAN EXPENSE CLAIM

**THIS FORM IS TO BE USED ONLY BY PARTICIPANTS IN THE
MEDICAL SERVICE PLAN**

Staff Member **Duty Station**
(SURNAME) (FIRST NAME)

Date of birth :/...../..... **ID number:**
(day/month/year)

Claim in respect of Myself

My Dependent :.....
(SURNAME) (FIRST NAME)

Date of birth:/...../.....
(day/month/year)

INSTRUCTIONS FOR SUBMISSION OF CLAIMS:

- 1) Complete this form for each participant and forward it to the **Health Claims Processing Unit (HCPU) Manila** for all officials world-wide, Geneva employees and field staff based all locations except Africa and Americas **or** to the Health Claim Processing Unit (HCPU) **Panama** for field staff based in Africa and Americas, together with the originals of receipted bills and doctors' prescriptions indicating the full name of the patient. Retain copy for your own records and ensure that claim is dated and signed by the staff member.
- 2) For certain medical treatment, a prior approval must be requested from the Medical Officer (MSP bulletin, paragraph 35).
- 3) Not more than **one claim will be processed each month for each participant**. However, in case of accident the participant may submit one claim for accident and one claim for illness during the same month.
- 4) **All accidents must be reported** before claims may be reimbursed. Notification of accident must be completed, signed and submitted no later than **eight (8) days** following the accident.
- 5) Claims will not be accepted if the amount claimed is less than the equivalent of **25 Swiss Francs** if submitted by locally-recruited Employees in field missions, or less than **100 Swiss Francs** if submitted by other participants.
- 6) All claims must be submitted **within twelve months** from the date of bill.

	Expense Type	Currency	Amount Expended	Amount Claimed
<p>This payment is certified as necessary for the amelioration or maintenance of the health of the participant.</p> <p>..... Date and signature of Medical Officer</p> <p>I certify that the prescriptions, bills, and receipts attached to this claim for reimbursement are genuine, that expenses are in accordance with average local rates and that I have not previously claimed for the same expenditure under this plan or under another insurance or from a third party. I undertake to inform the Organization of any amount reimbursed to me under another insurance or by a third party.</p> <p>..... Date and signature of staff member</p>	General Health Ambulatory			
	General Health Hospital			
	Optical			
	Dental			
	Orthodontic			
	Prosthesis Dental/Implants			
	Prosthesis other Type			
	Thermal Cures			
	Maternity Ambulatory			
	Maternity Hospital			
	Non Occupational Accident Ambulatory			
	Non Occupational Accident Hospital			
	Periodic examination			
	Exit Examination			
	Total claimed:			

Remarks