Zahtev za naknadu troškova medicinskih usluga
Application for Compensation for the costs of medical services rendered

WIENER STÄDTISCHE
VIENNA INSURANCE GROUP

Broj polise / Policy No.	

OSIGURANIK / INSURED (čitko popuniti sva polja)

IME I PREZIME / NAME & LAST NAME	DRŽAVLJANSTVO / CITIZENSHIP
JMBG / UIDN	TELEFON / TELEPHONE
BROJ ID KARTICE / ID CARD NO.	E-MAIL
ULICA I BROJ, MESTO, POŠTANSKI BROJ / STREET AND NO. POSTAL CODE, CITY	VLASNIK TEKUĆEG RAČUNA / ACCOUNT HOLDER
	BROJ TEKUĆEG RAČUNA ZA ISPLATU / BANK ACCOUNT NUMBER FOR PAYMENT

☐ Saglasan sam da Osiguravač na navedenu mail adresu može elektronski dostaviti obaveštenje i odluku u vezi ovog zahteva, što će se smatrati urednim dostavljanjem tih akata.

☐ I agree that the Insurer may electronically submit the notification and decision regarding this request to the specified e-mail address, which will be considered as proper delivery of these acts.

Podaci o pruženoj medicinskoj usluzi / Particulars of the medical service rendered

1. Razlog javljanja lekaru/zdravstvenoj ustanovi / Reason for the first call to the health institution
2. Izvršena medicinska usluga / Medical service rendered
3. Datum izvršene medicinske usluge / Date of medical services rendered
4. Iznos troškova izvršenih medicinskih usluga/kupljenih lekova / Total costs of medical services rendered/purchased medications RSD

Izjavljujem da su gore navedeni podaci tačni i istiniti. Ovlašćujem svakog lekara, zdravstvenu ustanovu i apoteku da mogu pružiti sva obaveštenja u vezi sa prijavljenim osiguranim slučajem koje predstavnici Wiener Städtische osiguranje a.d.o. od njih budu tražili, kako bih nadoknadio nastale troškove pruženih medicinskih usluga.

OBAVEZNA DOKUMENTACIJA KOJA SE PRILAŽE UZ OVAJ ZAHTEV:

- Original fiskalnih računa o izvršenim uslugama,
- Kopija medicinske dokumentacije u vezi sa pruženom uslugom,
- Broj dinarskog tekućeg računa (potvrda banke ili fotokopija osnovne banko-kartice bez njenog serijskog broja),
- Zahtev za preautorizaciju, ukoliko je vršeno prethodno odobrenje troškova,
- Ostala dokumentacija na zahtev osiguravača.

Potpisom na ovoj prijavi osiguranik/oštećenik/korisnik potvrđuje da je upoznat da će osiguravač njegove lične podatke koji su sadržani u ovoj prijavi, kao i sve druge relevantne podatke koji u postupku obrade štete budu utvrđeni i prikupljeni od trećih lica, čuvati, obrađivati, koristiti i preneti svojim zaposlenima i trećim licima (u skladu sa zakonom) sa kojima osiguravač ima zaključen ugovor o pružanju usluga, reosiguranju ili saosiguranju, a u svrhu izvršenja obaveza određenih ugovorom o osiguranju.

Svojim potpisom osiguranik/oštećenik/korisnik potvrđuje da je izričito saglasan da osiguravač njegove podatke iz prethodnog stava može čuvati, obrađivati i koristiti u statističke svrhe, u svrhe praćenja rizika u toku trajanja osiguranja i procene rizika pri obnovi ili zaključenju budućih ugovora o osiguranju, kao i da ih može proslediti trećim licima sa kojima osiguravač ostvaruje saradnju u postupku likvidacije štete i trećim licima koja po zakonu i prirodi posla koji obavljaju moraju imati pristup tim podacima.

I do hereby declare that the above data are accurate and true. I do authorize any doctor, health institution and pharmacy to provide any information related to the registered case insured as asked by the representative(s) of Wiener Städtische osiguranje a.d.o. in order to compensate for the costs arising from medical services rendered to me.

MANDATORY DOCUMENTATION TO BE ENCLOSED WITH THIS APPLICATION:

- Bill for the medical services rendered, including fiscal slip - originals,
- Complete medical documentation related to the service rendered – copy of documentation,
- Current account number (bank confirmation or copy of bank card without its serial number),
- Application for pre-authorization if prior cost authorization was performed,
- Other documents as required by the Insurer.

By signing this application, the insured / injured party / user confirms that he is aware that the insurer will keep, process, use his personal data contained in this application, as well as all other relevant data that are determined and collected from third parties in the claims processing procedure. and transferred to its employees and third parties (in accordance with the law) with whom the insurer has concluded a contract for the provision of services, reinsurance or co-insurance, for the purpose of fulfilling the obligations specified in the insurance contract.

By his signature, the insured / injured party / beneficiary confirms that he expressly agrees that the insurer may store, process and use his data from the previous paragraph for statistical purposes, for the purpose of monitoring risks during the insurance period and risk assessment when renewing or concluding future insurance contracts. and to be able to forward them to third parties with whom the insurer cooperates in the process of liquidation of damages and to third parties who, by law and the nature of the work they perform.

Mesto, datum / Place, date

Potpis osiguranika (za maloletna lica potpis roditelja)
Signature of the Insured (For minors, parental signature)

Oznaka: WS.C05.0.Z.22.112