REPUBLIC OF CYPRUS

MINISTRY OF HEALTH

APPLICATION FORM FOR REIMBURSEMENT OF COST

ΜΕΡΟΣ I: : PERSONAL DETAILS OF THE APPLICANT OR A PERSON ACTING WITH THE CONSENT OF THE PATIENT OR A PERSON LEGALLY EMPOWERED TO ACT ON BEHALF OF THE PATIENT

Name:.. Surname...

Date of Birth:....../......../.............. Identification Card No:...

Address:..., No.: ...., City/Town:.....................................

Postal Code:................., District:........................., Country: ....

Telephone No.: ...., E-mail :...

Facsimile No:.............................

SECTION II: HEALTHCARE SERVICE PROVIDED

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SECTION III: DECLARATION

I declare that I have knowledge of the provisions of the Law, that all the information I have provided as well as the submitted certificates/ documents are true and completed and that I am (deleted) consent all these information to be forwarded to another Governmental Department for verification of the specific request and notified to the competent authorities of another Member State if this is necessary. I also authorize the Ministry of Health to be able to ensure all necessary information for the purpose of verifying my specific requirement.

I understand that the Ministry of Health is not liable for the healthcare received in another Member State on the basis of the Directive on the application of patients' rights in cross-border healthcare.

I further confirm that the patient is a permanent resident of the Republic of Cyprus and beneficiary of healthcare treatment in accordance with the Laws of the Republic of Cyprus.

I declare that I am the patient / I am acting with consent of the patient / I am legally empowered to act on behalf of the patient (*delete what is not applicable)*

Name and Surname of the Applicant: ....

Signature: .... Date: ....

SECTION IV: REQUIRED DOCUMENTS

1. Copy of prior authorization document (in case this is applicable)

2. The original invoice or/and the original payment receipt or/and a certified copy of the medical prescription and payment receipt from the Pharmacy *(depending on a relevant Legal Order on reimbursement or not of pharmaceuticals and medical devices).*

3. Copy of the medical report from the medical centre or the responsible healthcare provider in case of prior authorization

4. The completed and signed authorization form for Payments by FIMAS, along with a written confirmation from the Bank stating the International Bank Identification Number (IBAN)

5. Copy of Medical Identity Card or relevant certificate issued by the responsible sector of the Ministry of Health.

The present application form should be returned ***duly completed*** *to the National Contact Point of the Ministry of Health through e-mail: ncpcrossborderhealthcare@moh.gov.cy or through facsimile on +357 22 605 499 / 492* ***and*** *through regular mail or by Hand to the Ministry of Health, 1 Prodromou and 17 Chilonos street, 1448 Nicosia, Cyprus.*

For official use only:

☐ Cross-Border Healthcare

☐ Scheme for the provision of Financial Assistance for Health Services not provided by the Public Sector

☐ Regulation for the Coordination of Social Security System