Szervezeti egység gazdasági / finanszírozási munkatársa Költségvállalási nyilatkozat (angol)

DECLARATION OF COMMITMENTS

Surname of the insured: ……
First name of the insured: …….
Date of birth of the insured: ……..

Passport number of the insured: ……

Clinical department where planned treatment to be carried out:

……

Treatment is planned in: outpatient care / inpatient care

Reference of outpatient / inpatient care planned treatment is based on:

…….

Diagnosis: ……..
Responsible party: Insurance account: ……..

Percentage of cost to be covered by insurance company

Will additional, extra cost be covered? yes / no

If yes, further details: …….

Contact person's (at the insurance company) e-mail address:

…….

Fax number: ……
Telephone / mobile number: ……..

Date: ……

signature of the insured ……

signature of the authorised person at the

insurance company ……

official stamp of the insurance company ……

made: 2 copies
1. copies.: Szervezeti egység
2. copies: patient