Aevitae
P.O. Box 2705
6401 DE Heerlen

Declaration Form for Travel Costs of Seated Patient Transport

Insured person

Forname and surname: _____ Policy number: _____

Address: _____ House number: _____

Postal code: _____ Town/city: _____

Phone number: _____ Date of birth: __ __ - __ __ - __ __ __ __

What are the costs to do with?

Do you have an authorisation for all destinations and periods? ○ Yes ○ No

If not, please apply for this now using the Form for Medical Declaration of Seated Patient Transport via www.aevitae.com.

Transported by

○ Own transport	We will use the route planner for the number of kilometres travelled. (No reimbursement for parking costs)
○ Public transport	Please enclose the train tickets and/or travel and transaction summary.
○ Taxi	Please enclose the original taxi receipts. (On the taxi receipts must be shown who was transported on what date and the departure and arrival points.)

In all cases, please enclose the appointments card. If you send in your travel declaration, please ensure that the enclosed appointments card is provided with a signature and stamp from your treatment location.

Transported from and to

Date of transport	From (name of institution and postal code)	To (name of institution and postal code)	Amount for public transport or taxi	Journey out km	Journey back km

Date of transport	From (name of institution and postal code)	To (name of institution and postal code)	Amount for public transport or taxi	Journey out km	Journey back km

Declaration

Reimbursement is only possible if you have received authorisation from us for the travel costs to be declared. In order to proceed to reimbursement of the authorised travel costs, it is necessary that you complete this form in full. It applies to all means of transport that you must enclose the original appointments card or a written declaration from the care provider with treatment dates. If you still need the appointments card for later appointments, a copy will suffice.

Undertaking

The undersigned declares that the form has been completed truthfully. I know that incorrect/partial completion of this form or concealment of facts relevant to the insurance policy/policies could lead to the declaration being invalidated. By signing, I give permission if necessary to seek information from the doctor/specialist treating me to verify my declaration.

Date: __ __ - __ __ - __ __ __ __ Signature: _____

Send the fully completed and signed form with the enclosures in to:

Aevitae

P.O. Box 2705

6401 DE Heerlen