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| **NAME** |  |
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| **EMBASSY/COMPANY** |  |

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| **N°** | **NAME OF PATIENT** | **DATE** | **MEDICAL SERVICES** | | **AMOUNT** | **CURRENCY** |
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| In order to be reimbursed please add **medical prescription** for all medicines, optical expenses, physiotherapy expenses, etc. ***If you buy several products from the pharmacist, please highlight on the receipt the drugs that appear on the prescription.*** | | | | **TOTAL** |  |  |

I hereby certify that all the information mentioned above is correct. *Signature*I hereby certify that I am not entitled to any other health insurance system.