

Prior agreement application

Series of procedures and medical prostheses

Series of procedures will only be reimbursed by Henner if the Medical Advisory Board has granted a prior agreement based on the information in this document, which must be completed by the Practitioner and sent by post, fax or email to:

Henner Medical Advisor
14 boulevard du Général Leclerc
92200 Neuilly-sur-Seine Cedex – France

Fax: +33 (0)1 85 64 74 15
Email: medical@henner.com

This form must be sent no later than 15 days prior to the date scheduled for the beginning of the treatment.

Insured member's first and last name:

ID Number:

Patient's first and last name:

Date of birth:

Gender:

If the current prior agreement application directly related to an accident? Yes No

If so, please also attach a detailed report describing the circumstances of the accident.

To be completed by the attending practitioner

The following procedures are subject to this prior agreement application:

Type 1 treatments: acupuncture, chemotherapy, dialysis, electrotherapy, physiotherapy, radiotherapy, kinesitherapy, speech therapy, orthoptics, nursing care, medical prostheses ⁽¹⁾

Type 2 treatments: Psychiatric or psychotherapeutic treatments (may only be reimbursed if treatment is given by a physician)

(1) Medical prostheses: enclose the prescription

Details of medical condition

Reason for treatment:

Clinical symptoms presented:

Precise medical diagnosis (including ICD-Code):

Date on which the patient first became aware of any signs/symptoms of this condition (dd/mm/yyyy):

Date on which the patient first consulted any doctor for this condition (dd/mm/yyyy):

Date on which the patient was diagnosed with this condition (dd/mm/yyyy):

Type 1 treatments

Nature of procedures:

Total number of procedures:

Total cost (specify incurred currency):

Type 2 treatments

Medical history:

Family history:

Patient's personality:

Type of therapy considered:

Behavior contract:

Purpose of the therapy with expected results:

Total number of sessions:

Frequency of sessions:

Cost of each session (specify incurred currency):

Physician's seal and signature:

Patient's signature:

Date:

For a medical information: +33 1 55 62 53 42

I hereby authorize my Physician to send all the medical information required for deciding on my file to Henner's medical advisor.