Nyilatkozat EU állampolgár térítésmentes ellátásra jogosultságáról

(angol nyelven)

Regulations on Payment for Health Services
DECLARATION BY EU CITIZEN

ON ELIGIBILITY TO FREE MEDICAL SERVICES

Me, the undersigned citizen of the European Union, hereby acknowledge that free treatment was provided to me at the Ward/Unit of ..... of Kenezy Teaching Hospital. Neither at the beginning of, nor during, the treatment could I certify my eligibility to free medical services. Therefore, by this declaration, I undertake to send the form required for eligibility to free services or the completed insurance card through fax and by registered mail to the Ward/Unit ..... of Kenezy Teaching Hospital, at which the services had been provided to me (H–4031, Debrecen, Bartók B. utca 2–26), within fifteen (15) calendar days. At the same time I acknowledge that after the specified deadline expires the ward/unit providing the services will institute an action for the collection of the costs by legal means and that the costs of the procedure will be charged on me.

PATIENT INFORMATION
Family name:.....
First name: .....
Middle name: .....
Address: .....
Country: .....
City/Town: .....
Street/House number: .....

INSURANCE INFORMATION
Bearer of costs: .....
Address of the bearer of costs: .....
Insurance valid from: .....
Contact data of the insurance administrator: .....
Dated at Debrecen, …. (day)…….(month)……..(year)
I have been informed of, and understood, the content of this document in the language I speak. I undertake full liability for its content.

…….
patient's signature

Enclosures: a copy of the passport, a copy of the identity card, a copy of the driving licence (to be underlined as applicable)
Before us as witnesses:

Witness 1:	Witness 2:
……	……..
(name, address)	(name, address)