Power of Attorney for Reimbursement Payment to an Insurance Company for Medical Treatment Abroad

1. Information about the grantor (Policyholder)

Name	National ID number
Address	
Postal code	City

2. The power of attorney applies to the following treatment

Country of treatment	Period of treatment
Type of treatment	
Reason for recieving treatment	
Did you use the European Health Insurance Card in connection with the treatment?	Yes ☐ No ☐

3. Information to be filled out by the insurance company

Insurance company	Organization number
Recipient of payment	Account number for payment
Reference number for submission	

4. Connection to the country the treatment was provided

Indicate the number of weeks you have stayed and plan to stay in the treatment country

This year:

Last year:

	Yes	No
Are you employed, self-employed or au pair?	☐	☐
If yes, in which country?		
Do you receive sickness benefits, unemployment benefits, parental benefits, or work assessment allowance from Norway?	☐	☐
Do you recieve a pension or disability benefit from Norway?	☐	☐
If yes, do you recieve any of the following pensions:		
Public AFP ☐ Private AFP without drawing old-age pension from the National Insurance Scheme	☐	
Are you studying in another EEA country?	☐	☐
If yes, in which country?		
Do you have a spouse or cohabitant residing in the treatment country?	☐	☐
Do you have children under the age of 18 residing in the treatment country?	☐	☐
Do you have a residence in the treatment country?	☐	☐

5. Signature of the grantor (Policyholder)

This power of attorney is limited to medical treatment received in the country and period mentioned above. By signing this power of attorney

- I transfer my claim to the insurance company
- I consent to the exchange of necessary information between Helfo and the insurance company/companies
- I consent to the exchange of information regarding any user fees related to my exemption card
- I consent to the collection and use of my health information in accordance with the Health Register Act and the Personal Data Act

☐ I confirm that the information provided in this form is correct and complete.

Place and date	Signature

1. Health services for which reimbursement is requested

Did the need for treatment arise before the policyholder traveled abroad?

Yes* ☐ No ☐

*If yes, a referral must be attached

Date*	Place of treatment	Health service	Amount paid in local currency

*For hospital treatment use date from–to.

Total amount 0

2. Attached documentation

The following documentation must be attached to all claims:

- ☐ Power of attorney
- ☐ Original medical report
- ☐ Translated medical report
- ☐ Itemized invoice
- ☐ Proof of payment

If the documentation is in other language than Norwegian, Swedish, Danish og English, you must provide a traslation.

For planned treatment in another EEA country, also attach:

- ☐ Referral from Norwegian healthcare personnel

By checking the boxes the insurance company confirms that the documentation is attached.

3. Signature

Place and date	Signature