Please send this form to:

Helfo
Postboks 2415
3104 Tønsberg
NORWAY

Application for reimbursement for infertility treatment in an EEA country

The applicant(s) must complete this form. **It is quicker to send this form in electronically.** The due date for applying for reimbursement of expenses is 6 months after completion of each IVF attempt.

For each attempt (including FET attempts), you must send us a new form providing details of that attempt. If you are applying for reimbursement of expenses on drugs, the time limit is 6 months from each purchase. See also the list of enclosures.

More information about the terms for this type of financial assistance is available at helsenorge.no. Helfo advises claimants to study this information carefully.

PLEASE ONLY USE PAPER CLIPS ON RECEIPTS.

1. Information on the applicant(s)

Name of applicant	Name of partner
National ID no. (11 digits)	National ID no. (11 digits)
Postal address	Postal address
Postal code, city	Postal code, city
Telephone no. of applicant	Telephone no. of partner
Account no.	
E-mail address	

2. Connection to the country in which treatment was provided

How weeks a year do you spend in the country of treatment (estimate)?

This year:

Last year:

	YES	NO
Are you employed or self-employed in Norway?	☐	☐
Are you receiving welfare benefits such as sick pay, unemployment benefit, parental benefit or work assessment allowance from Norway?	☐	☐
Are you receiving an old age pension or disability pension from Norway?	☐	☐
Are you employed or self-employed in another EEA country?	☐	☐
If yes, which?		
Are you studying in another EEA country?	☐	☐
If yes, which?		
Do you have a spouse or partner in the country of treatment?	☐	☐
Do you have any children under the age of 18 in the country of treatment?	☐	☐
Do you have housing in the country of treatment?	☐	☐

3. Prior notification

A. Did you apply for and receive prior notification from Helfo?	YES ☐	NO ☐
B. If Yes: did you have treatment not comprised by the prior notification?	YES ☐	NO ☐

4. Referral

Have you been referred for infertility treatment by a healthcare professional in Norway?	YES ☐	NO ☐
Who referred you?		

5. Expenses you are applying for

Date	Details of treatment	Amount paid in local currency
	Total	0

6. List of enclosures supporting your application*

Tick to confirm	Documentation of infertility treatment	Enclosure no.
☐	For non-hospital treatment: a copy of the treatment provider's license to practice or specialist authorisation from the country providing the treatment	
☐	Medical record/discharge summary from abroad	
☐	Records from previous infertility treatment in Norway, if any	
☐	Referral letter from a Norwegian healthcare professional	
☐	Original itemised bill	
☐	Original receipt or other proof of payment such as a bank statement	
☐	Form:"Personal statement from the applicant and partner-abroad-05-24.14"	
☐	Form from the treatment provider: "Statement from the treating physician regarding assisted reproductive treatment abroad-05-24a.06"	
	Documentation for the purchase of drugs	
☐	Prescriptions	
☐	Package or copy of package showing active substance	
☐	Original receipts itemising the name of the drug, number of packs and price	
☐	If you are applying for reimbursement of drugs not marketed in Norway, this form: "Statement from spesialist regarding need for drugs not marketed in Norway - infertility treatment-05-24a.08"	

* All documentation must be in Norwegian, Danish, Swedish or English. For more information on this, see 'General information' on the last page.

7. Travel expenses

Do you wish to apply for Patient Travel to cover travel expenses? Yes ☐ No ☐

8. Applicant(s) signed consent*

I give my consent for my application including enclosures to be forwarded to the specialist health service if Helfo requires assistance in determining my entitlement to reimbursement and the amount.	☐
(If applicable as partner) I also give my consent for Helfo, the Norwegian specialist health service and regional health authority units to exchange relevant health data on me or the status of other claims if necessary for processing my application. In signing this form, I consent to procurement and use of my health data; see the Norwegian Health Registry Act and Personal Data Protection Act.	☐

We hereby certify that the information provided in this form is accurate and complete:

Place and date	Applicant's signature
Place and date	**The partner's signature**

*If you do not give your consent for exchange of information between Helfo and the specialist health service, Helfo may not be able to process your application because it is not supported by sufficient medical information.

Information on the translation requirement

In order for Helfo to consider the claim and reach a decision, the documentation must be comprehensible. This means that all documentation must initially be in Norwegian, Danish, Swedish or English. You should therefore try to get the documentation issued in one of these languages. If the documents are in another language, Helfo can, if necessary, ask you to have them translated. You must pay for the translation yourself. If you send in a translated document, you must also send in the original.