REQUEST FOR INFORMATION [1] ON ECONOMIC AND LOGISTIC ASPECTS OF PLANNED TREATMENT ABROAD[2] E 112 (S 2)

*(**This request for information does not replace in any way the certificates envisaged by the Community legislation on social security**)*

Part A) To be filled in by the patient

1. Patient authorized by the relevant institution to receive planned treatment

Name, surname: …………………………………….

Date of birth: ……………………………….

Address in the Country of residence: ………………………………………

Personal identification number
indicated in the E 112 (S 2) form of authorization ……………………………………..

2. Health institution that will deliver the planned treatment

Name of clinic, hospital (*provider*): …………………………

Address: ……………………………….

State: ……………………………….

Part B) To be filled in by the Health institution concerned in the State where treatment is going to be provided

REQUEST FOR PAYMENT, IF ANY, AND CONDITIONS PROVIDING ACCESS TO TREATMENT THAT PATIENTS MUST BE AWARE OF BEFORE GOING ABROAD (tick boxes of interest and add relevant information)

No payment by patient ☐
(If this box is ticked the information requested below is not to be provided)

Date of reply

(Person in charge of liaison body of the State where treatment is to be delivered)

3.

Date of surgery/treatment/duration of treatment:

- Date of surgery has been set and/or period of treatment ☐ ....

There is a waiting list ☐ (indicate expected date/period for delivery of service) ……………

Costs [3] **that patient must pay to the** ***provider***:

- to have access to waiting list ☐ ………………… (indicate amount)

- advance payment ☐ co-payment charge ☐ other contribution to costs ☐ . …………………. (indicate amount)

- for transportation from one health facility to another ☐ ……………..….. (indicate amount)

- for cost of surgery team ☐ ……………..….. (indicate amount)

- difference between actual cost of service and DRG rate ☐ ……… …(indicate amount)

- for single room as against rooms with several beds ☐ ……… …(indicate amount)

- Other services for which payment is requested ☐ (indicate nature and amount):

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TOTAL COST TO BE PAID BY PATIENT [3]……………………………

It is hereby declared that the above payments and conditions for access charged to Italian patients also apply to the residents of the State where planned treatment is to be delivered.

Date of reply

(Person in charge of liaison body of the State where treatment is to be delivered)

NOTES (1) Cooperation between competent authorities - (Article 84 of EEC Reg. n° 1408/71) – Article 76 EEC Reg. n° 883/2004: "…The institutions, in accordance with the principle of good administration, shall respond to all queries within a reasonable period of time and shall in this connection provide the persons concerned with any information required for exercising the rights conferred on them by this Regulation". Only part B is to be filled in (2) Planned treatment: Article 26 of EEC Reg. n° 987/2009 (Article 22 of Reg. n°. 574/72); (3) Indicate costs in Euro, or specify currency if payment is not made in Euros.