

## Cost Estimate form

COST ESTIMATE FOR HOSPITALISATION OF  Mr  Ms \_\_\_\_\_

NAME OF (FORMER) MEMBER OF PERSONNEL \_\_\_\_\_

VANBREDA PERS. REF. NO. \_\_\_\_\_ / \_\_\_\_\_

ORGANISATION \_\_\_\_\_

### To be completed by the hospital and/or physician

NAME, ADDRESS, TEL./FAX OF HOSPITAL, NAME CONTACT PERSON  
 USA HOSPITALS: PLEASE ALSO MENTION THE AREA CODE

NAME, ADDRESS, TEL./FAX OF PHYSICIAN

DIAGNOSIS OR REASON FOR ADMISSION (1) - (2)

TREATMENT/INTERVENTION

MEDICAL REPORT ON THE ILLNESS/TREATMENT IN ANNEX (1) - (2)?  YES  NO

EXPECTED DATE OF ADMISSION (D - M - Y)

LENGTH

EXPECTED DATE OF DISCHARGE (D - M - Y)

EXPECTED COSTS OF THE HOSPITALISATION

#### OPTION A

ROOM: PRIVATE	PRICE = _____ /DAY
SEMI-PRIVATE	PRICE = _____ /DAY (MANDATORY INFORMATION)
WARD	PRICE = _____ /DAY

OTHER HOSPITAL EXPENSES = \_\_\_\_\_

(E.G. MEDICINES, X-RAYS, LAB, ETC)

DOCTORS' FEES WITH RELEVANT BREAKDOWN (3) = \_\_\_\_\_

(FOR USA: PLEASE USE CPT-CODE)

#### OPTION B

ALL-IN RATE = \_\_\_\_\_ /DAY

SHOULD A LETTER OF GUARANTEE BE SENT TO THE ABOVE MENTIONED HOSPITAL?  YES  NO

DATE AND SIGNATURE OF (FORMER) MEMBER OF PERSONNEL (4)

STAMP OF HOSPITAL/PHYSICIAN

(1) All information subject to medical secrecy may be sent for the attention of our medical consultant in a sealed envelope.

(2) Diagnosis and medical reports should be legible and without abbreviations.

(3) In case of surgery, the fee of each member of the surgical team; in case of conservative treatment, the fee of the main treating physicians.

(4) In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian Law of December 8, 1992 concerning the private life).