Questionnaire
for your attending complementary medicine specialist

This questionnaire serves to clarify the disbursement of further complementary treatment benefits. Would you like to complete this form online and learn more about our processing of benefits? If so, visit us at: **helsana.ch/complementary-therapist**.

Details of insured person

Insurance no.	
First name, Surname	
Street, house no.	
Postcode, Town/City	
Date of birth	

Note:
All questions must be answered in full so that we can check our duty to provide benefits.
Please fill out the form in block capitals – thank you.

Attending complementary medicine specialist/ coordinating doctor

First name, Surname	
EMR-ZSR-Nr.	

1. Do you have a close relationship with the insured person (parent/ child/spouse) or do you live in the same household?
   - ○ Yes
   - ○ No

2. Is the insured person employed?
   - ○ No
   - ○ Yes, current professional occupation:

3. Reason for treatment:
   Please only select one answer.
   - ○ Illness
   - ○ Accident
   - ○ Pregnancy
   - ○ Prevention

   Date
   - ○ Maternity

4. Please state your current therapeutic or medical opinion and your diagnosis specific to your discipline or method.

5. What conventional medical treatments have been or are being applied and what is the conventional medical diagnosis (if known)?

6. What complaints are present? How do these complaints limit the insured person in their day-to-day and professional tasks?

6.1 Has the individual been certified as incapacitated for work by the attending physician (if known)?

- ○ Yes, degree in %
- ○ No
- ○ Unknown

7. What treatment method(s) are you using on the insured person?

7.1 What is the treatment plan and are any adjustments necessary/planned?

7.2 What therapeutic goals have been agreed/set?

7.3 What goals have been achieved or have had to be adapted since the treatment started and/or since the last report?
Please explain

8. What improvements or changes have been achieved through your treatment since the treatment started and/or since the last report?

9. What are you planning for the stated complaints/symptoms or illnesses?
Please only select one answer.

- ○ Treatment was or will be completed on:
- ○ Residual complaints/illnesses are present; final treatments are required
- ○ Complaints/illnesses are still present; conclusion of treatment is not yet foreseeable
- ○ Long term treatment is necessary
- ○ Treatments for prevention or for avoidance of relapses

10. Please specify the frequency of the recommended course of treatment going forward and the intended timeframe.
E.g. three treatments a month for six months

11. Can the frequency and timeframe of the treatments be reduced in future?
E.g. one treatment a month for three months

- ○ No, why not?
- ○ Yes, from when onward?

12. Is the insured person carrying out targeted health promotion measures?
E.g. fitness activities, health courses, relaxation methods, etc.

○ No
○ Yes, please specify:

13. Is the insured person also being treated by other complementary medicine service providers

○ Unknown
○ No
○ Yes
Who?

First name, Surname

Treatment method

By signing this document, you confirm that the information provided in this questionnaire is correct.

Place and date	Signature/official stamp, doctor, complementary therapist

Please send the questionnaire to the following address:
Helsana AG, Customer Service, Complementary Medicine Specialist, P.O. Box, 9008 St. Gallen