The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurances Ltd and Helsana Accidents Ltd.

Helsana

Helsana Group

Invoice form for PRIMEO benefits:
Pet care (one invoice for all pets)

Form for the reimbursement of benefits if no receipt/invoice is available.

Please complete the relevant fields truthfully and then send us the form via myHelsana, by e-mail or by post.

Important: Please only complete one invoice form for all of your pets (instead of completing a separate form for each pet).

Details of the insured person	**Details of the person/organisation providing the service**
First name Surname	First name Surname
Insurance no.	Street, house no.
Date of birth	Postcode, town/city
Street, house no.	Country
Postcode, town/city	PAR number: Bern: Q043997 Betreuung von Haustieren; St. Gallen: Q044097 Betreuung von Haustieren; Zurich: Q043697 Betreuung von Haustieren; Lausanne: Q043797 Garde d'animaux domestiques; Bellinzona: Q043897 Assistenza ad animali domestici

Pet care details

Date of pet care:
(This is an outpatient [one-day] benefit, e.g. 15.03.2024.)

Invoice amount/price:
(Please enter the amount in CHF, e.g. CHF 80.–)

Tariff item: H03.200.03

Other details of the pet

Species: (e.g. dog, cat, etc.)	
Are you the pet's registered owner? (Please mark)	Yes ○ No ○
Does the person providing the service live with you in the same household? (Please mark)	Yes ○ No ○

Details of the outpatient procedure

Date of the outpatient procedure being paid for under basic insurance:	
Name of the doctor, clinic or hospital:	
Reason for treatment/diagnosis: (Not mandatory)	

The data you enter will be processed by Helsana Supplementary Insurances Ltd (PO Box, 8081 Zurich) for the purpose of invoice verification.

The data will not be forwarded to third parties. You can find further information about data protection in our Privacy Policy at helsana.ch/data-protection.

The health insurance provider will make the payment to the patient.

I hereby confirm that I have read the form and completed it correctly and in full.

Place and date	Signature of insured person