CNS
d'Gesondheetskeess

Request for reimbursement
Other beneficiary

I, the undersigned,

Identification number	
Last and first name(s)	

certify that I have paid **all the invoices attached** and request that the corresponding reimbursements be paid into my bank account registered with the CNS.

Date and signature

Art. 84. Health care services may be validly paid either to the insured person or to any other person who can prove to have provided the service or met the related costs

Reserved for the CNS

Responsible service

Label

CNS entry stamp

B