

.....
(service provider's stamp)

Krakow, on

APPLICATION FORM
for a decision confirming entitlement to healthcare services financed from
public funds
(for the service provider).

Service provider's data (e.g., a hospital):

Name.....

Headquarters: (street, no., premises)
.....

(post code) (city/town)

Correspondence address): 1 (street, no., premises)
.....

(post code) (city/town)

I declare that on the day of emergency healthcare
services were provided to the recipient:

First name Last name
.....

PESEL number Identity Card number²
.....

- Address of residence: (street, no., premises)

.....

(post code)(city/town).....

- Residence address:³ (street, no., premises)

.....

(post code) (city/town).....

- Correspondence address:⁴ (city/town)

(post code) (city/town).....

The Provider's statement regarding the verification of the Recipient's entitlement to healthcare services financed from public funds.

The recipient has been checked in eWUŚ (Electronic Verification of Beneficiaries' Eligibility) and has not obtained confirmation of the entitlement to healthcare services financed from public funds.

Based on Art. 54 par. 4 in conjunction with art. 2 par. 1 point 2 of the Act of 27

August 2004 on health care services financed from public funds, I am asking for a decision confirming the entitlement of the above-mentioned recipients to healthcare services financed from public funds, from the date of granting emergency services.

.....
(signature of the person authorized to act on behalf of the healthcare provider)

¹ fill in if correspondence is to be delivered to an address other than the service provider's registered office

² or any other document confirming the recipient's identity

³ complete if the recipient has no place of residence

⁴ complete if the recipient provides a correspondence address other than the address of residence or stay