Patient Insurance centre

Compensation claim, vocational rehabilitation

You can use this compensation claim form to claim compensation for costs incurred by vocational rehabilitation after the Patient Insurance Centre has issued a favourable claims decision on the compensability of vocational rehabilitation.

Injury information

Patient Insurance Centre's claim reference number

Injured party

First name and last name

Personal identity code

Postal address (if changed)

Postcode, city and country

Phone number (if changed)

E-mail address (if changed)

Costs of vocational rehabilitation

Please provide the costs incurred in this section. Attach the invoices and receipts. Provide the travel expenses below. Use a different form to provide additional information, if needed. Additional information can also be provided using a separate attachment.

Cost 1

Date of cost

Amount in €

Type of cost

Cost 2

Date of cost

Amount in €

Type of cost

Cost 3

Date of cost

Amount in €

Type of cost

Cost 4

Date of cost

Amount in €

Type of cost

Cost 5

Date of cost

Amount in €

Type of cost

Cost 6

Date of cost

Amount in €

Type of cost

Travel expenses related to vocational rehabilitation

Please provide the necessary travel expenses. If you have received reimbursement for the travel expenses from elsewhere, specify the amount you paid as co-payment. You do not need to attach invoices or receipts to your claim. Please retain the receipts for one year from the date of this claim in case they need to be reviewed. For the use of a private car, we will pay EUR 0.33 per kilometer. Use a different form to provide additional information, if needed. Additional information can also be provided using a separate attachment.

This form is not for claiming reimbursement of travel expenses incurred in medical care related to the patient injury. For such expenses, please use form Compensation claim for patient injury.

Travel expense 1

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 2

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 3

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 4

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 5

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 6

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Travel expense 7

Date of travel

Length of trip (km) if private car was used

Choose one vehicle. If several vehicles were used, specify the dates of travel to and from the treatment on separate rows.

☐ Private car ☐ Taxi ☐ Public transportation

Route, from–to

Have you received travel expense reimbursement from elsewhere? Please specify where.

☐ Yes ☐ No

Travel expenses after other reimbursement

Additional information

If necessary, provide all other information required for processing your claim.

Signature

The party claiming compensation must undersign this form. Otherwise, the claim will not be processed.

With my signature, I affirm that all the information I have provided with this form and its appendices are correct and that I have not applied for or received any other compensation for the costs and losses I have claimed compensation for with this form other than the ones specified on this form and its appendices.

The Patient Insurance Centre has the right, without being prevented by provisions on personal data security, to obtain information that is necessary for handling a claim from insurance and pension institutions, authorities and other parties subject to the Act on the Openness of Government Activities (621/1999), employers, healthcare providers, parties performing rehabilitation, and parties providing social welfare services (Patient Insurance Act section 54). The Centre also has the right to obtain information on wages, salaries and benefits from the Incomes Register for the determination of the grounds for compensation and the scope of the liability to compensate (Act on the Incomes Information System, chapter 5, section 13).

By signing this document, I agree that doctors and other healthcare professionals, healthcare units, pharmacies and parties providing rehabilitation and other healthcare units, as well as providers of social welfare services and treatment institutions may provide the Patient Insurance Centre with claimant's documents and other material related to examination or treatment as well as information regarding the patient's state of health, working capacity and rehabilitation without being prevented by non-disclosure provisions, where such documents, material or information are related to the claimant's state of health and are necessary for the assessment of an injury case or the claims handling thereof.

I also agree that the tax authorities, the employers of the injured person, the pension and insurance institutions, the Finnish Centre for Pensions, Kela and other authorities may, without being prevented by non-disclosure provisions, give the Patient Insurance Centre the information, documents and decisions regarding the compensation and salary received by the claimant, which are necessary to resolve the compensation case.

By signing a compensation claim, I also give my consent to the Patient Insurance Centre to provide, if necessary and in connection with starting and implementing occupational rehabilitation, copies of all documents relating to me in the Patient Insurance Centre's possession and all other information it deems necessary to the institution planning and implementing the rehabilitation and to the institution that will carry out any possible related examinations.

Date _____ Signature of the claimant and name in block capitals _____

Attachments _____ pages

Empty form

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