



You can also file the application and related documentation online: www.kela.fi/english.



Send the application and any supporting documents by mail. The address is Kela, PL 10, 00056 KELA.

- i** If you have moved to Finland and you have not previously claimed benefits from Kela, also complete form Y 77e. If you are going abroad, also complete form Y 38e.

If you are in public institutional care or equivalent care, you are not entitled to reimbursement for medical care expenses incurred during this time.

Apply for reimbursement for travel expenses in the e-service OmaKela (www.kela.fi/english) or on form SV 4e (Claim – Reimbursement for travel expenses).

Apply for reimbursement for medical care expenses incurred abroad on form SV 128e (Claim – Medical care expenses incurred abroad).

Apply for reimbursement for medicine expenses incurred in Finland on form SV 178e (Claim – Medicine expenses incurred in Finland).

When to claim: File your claim within 6 months of the original payment.

1. Claimant

- i** Person for whose costs reimbursement is claimed.

Personal identity code

Family name and given name

Telephone

E-mail

- i** Kela retrieves address data from the population data system.

2. Bank account number

- i** If you have an account with a foreign bank, please also state the BIC code of your bank. If you authorise another person or your employer to receive the reimbursement for your medical care expenses, indicate the authorised person's or employer's bank account number under section 6.

3. Expenses incurred

- i** You can claim reimbursement for the medical care expenses when you use private healthcare services due to illness, pregnancy, childbirth or dental care.

Reimbursement is only paid for the examinations and treatment procedures if they are needed for fertility treatment or mental health or oral health. You can get reimbursement if the examination or treatment was ordered by an obstetrician/gynaecologist, a psychiatrist, a dentist, a specialist dentist or an oral and maxillofacial surgeon. Examinations performed by a psychologist are reimbursed, if you have a doctor's referral for the examinations.

How were the expenses incurred?

- ☐ Illness, pregnancy, childbirth or dental care
☐ A traffic accident
☐ An occupational disease or industrial accident

- i** If the expenses are due to a traffic accident, an occupational disease or an industrial accident, state the name of the insurance company that handles the case. Also complete form SV 143e (Accident report).

Name of insurance company _____

4. Enclosures

- i** Visits to a dental hygienist can be reimbursed without a referral from a dentist for up to twice per calendar year. Reimbursement is available for physiotherapy provided by a physiotherapist without a referral from a doctor for up to 4 times per calendar year. Reimbursement from Kela for the costs for physiotherapy is not available after the 4th visit, even if you have a referral from a doctor.

Enclose statements and referrals for examination or treatment that you have received from the treatment provider.

- ☐ Statement of treatment provided by a doctor and fees paid
- ☐ Statement of fertility treatment provided by an obstetrician/gynaecologist and fees paid
- ☐ Statement of treatment provided by a dentist/specialist dentist and fees paid
- ☐ Prescriptions for examination or treatment issued by an obstetrician/gynaecologist (form SV 3H), a psychiatrist, a dentist, a specialist dentist or an oral and maxillofacial surgeon (form SV 3 or SV 3SHM) and documentation on the treatment provided on the basis of the prescriptions
- ☐ Statement of treatment provided by a dental hygienist and fees paid, no referral from a dentist
- ☐ Statement of treatment provided by a physiotherapist and fees paid

- i** If you need copies of the documents, take the copies before submitting the claim to Kela or the workplace sickness fund.

5. Signature

- i** The claim can be signed by the claimant, the claimant's legal guardian or representative, close relative or another person with main responsibility for the welfare of the claimant.

I declare that the information I have given is true and accurate.

Place and date

Signature, printed name and the signatory's phone number

6. Power of attorney

I hereby authorise the person or employer named below to collect any reimbursements awarded to me.

Name and personal identity code of the authorised person or name and business ID of the authorised employer

Address of the authorised person or employer

Postal code

Postal district

Bank account number of the authorised person or employer

Name and telephone number of the employer's representative

Place and date

Signature and printed name of the grantor

