BUDGET HEALTH MEDICAL AID CLAIM FORM

MEMBER/PATIENT TO COMPLETE ALL RED SECTIONS

PM STAFF

WHOLE CLAIM COMPUTE R INSTRUCTIONS

PLEASE INDICATE MEDICAL AID SOCIETY WITH AN "X"

☐ BUDGET ☐ BON VIE ☐ CIMAS ☐ ENG ☐ GENHEALTH ☐ MASCA ☐ MUN. BYO. ☐ MUN. HRE. ☐ N'THERN ☐ RAILMED ☐ OTHER SPECIFY _____

PLEASE PRINT MEMBER'S NAME _____

POSTAL ADDRESS _____

CONTACT TEL. NO. _____

NAME OF EMPLOYER/GOVT. DEPT. _____

IF THIS TREATMENT IS DUE TO AN ACCIDENT, PLEASE PUT "X" IN THE APPROPRIATE BOX.

☐ ROAD TRAFFIC ACCIDENT

☐ ACCIDENT AT WORK

☐ OTHER- SPECIFY

PATIENT'S NAME	RELATIONSHIP TO MEMBER	MEMBER'S NUMBER	PATIENT'S SUFFIX No.	PATIENT'S DATE OF BIRTH

BEFORE SIGNING, PLEASE NOTE:

1. IF YOU SIGN THIS CLAIM FOR ANY TREATMENT WHICH HAS NOT BEEN PROVIDED YOU WILL BE COMMITTING AN OFFENCE. IF YOU BECOME AWARE THAT THE CLAIM IS SUBMITTED FOR SERVICES WHICH HAVE NOT BEEN PROVIDED YOU MUST CONTACT YOUR MEDICAL AID SOCIETY FORTHWITH.

2. IF YOU HAVE PAID FOR THIS TREATMENT, YOU SHOULD SIGN THE FORM ONCE ONLY BEFORE SENDING IT TO YOUR MEDICAL AID SOCIETY. ATTACH YOUR RECEIPT AND INSERT THE AMOUNT YOU ARE CLAIMING IN THE APPROPRIATE BOX ALONGSIDE YOUR SIGNATURE.

SIGNATURE	DATE	RELATIONSHIP TO MEMBER	FEE CHARGED (IF KNOWN)

I CONFIRM THAT THE DETAILS GIVEN ABOVE ARE CORRECT, THAT THE AMOUNT CLAIMED HEREIN IS NOT CLAIMABLE FROM ANOTHER SOURCE, AND THAT THE PATIENT ISA MEMBER OR DEPENDENT OF THE MEDICAL AID SOCIETY SHOWN ABOVE.I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS AND TO GIVE ACCESS TO ANY TREATMENT NOTES TO THE MEDICAL AID SOCIETY FOR ITS CONFIDENTIAL USE.

FOR COMPLETION BY PROVIDER OF SERVICES

AHFOZ PAYEE No. _____ DATE CLAIM CLOSED _____ (DAY MONTH YEAR) ACCOUNT REF. No. _____

AHFOZ NOS. _____

NAME OF REFERRING PRACTITIONER (IF ANY) _____

NAME OF ANAESTHETIST (IF ANY) _____

NAME OF SURGICAL ASSISTANT (IF ANY) _____

LINE		TARIFF No.	MODS.		QTY.	DA	MONTH		YEAR				FEE CHARGED	
01	M													
02	M													
03	M													
04	M													
05	M													
06	M													
07	M													
08	M													
09	M													
10	M													

GROSS AMOUNT CLAIMED $ _____

I hereby certify that, I, or members of my staff, have rendered the above services to or on behalf of the patient. I confirm that to the best of my knowledge the patient treated is the patient named on this form. I agree that any claim for services not provided would be regarded as fraudulent and render the person concerned liable to prosecution.

DIAGNOSIS _____

SIGNATURE& OFFICIAL STAMP OF PROVIDER OF SERVICES

DATE

☐ If there are any other matters you wish to bring to the attention of the medical aid society, tick this box and make your comments overleaf