Claim Form

08677 400 500
connect@cimas.co.zw
cimas.co.zw
fb.com/cimasmedicalaid
East Block, Borrowdale Office Park
P.O. Box 1243, Harare, Zimbabwe

Member/Patient to complete all blue sections. Print at all times.

Member Name

Postal Address

Mobile Number

Email Address

If this treatment is due to an accident please put an "X" in the correct box below

- Road Traffic Accident
- Accident At Work
- Other - specify overleaf

Name of employer/Government department

Patients Name

National ID number

Relationship to member

Member Number

Suffix number

Date of birth

Before signing in signature box below please note: -

1 If you sign this claim for any treatment which has not been provided you may be committing an offence if you become aware that the claim is submitted for services which have not been provided you must contact Cimas Medical Aid Society forthwith.

2 If this treatment has not been paid for then you must either sign each day the treatment is received or once daily after the provider of services has inserted all his/her charges.

Note - claim forms that are signed before the day on which the treatment is to be received will be rejected.

3 If this treatment has been paid for you should sign the form once only before sending it to Cimas 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 is a member or dependent of Cimas Medical Aid Society. I authorise the provider of services to disclose the nature of illness to Cimas for its confidential use and I agree that no awards will be made for this treatment unless contributions are received in respect of the period of treatment.

For completion by provider of services

PCN

AHFoZ number

Date claim closed

Account reference

Name of referring practitioner | PCN | AHFoZ number

Name of anaesthetist | PCN | AHFoZ number

Name of surgical assistant | PCN | AHFoZ number

Line		Tariff Number	Mods	Mods	Qty	Year	Month	Days	Fee charged
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									

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

ICD-10 code

Signature .... Date ....

Official stamp of provider of services ....

If there are any other matters you wish to bring to the attention of Cimas tick this box and make your comments overleaf